

Pulmonary Disease and Critical Care Associates Health Questionnaire

Date of Visit: _____

Patient Name: _____ **SS#:** _____

Present Problem (Reason for Visit): _____

Start of problem: _____

List all medications you are now taking (include herbal meds & those you buy without a prescription)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list any allergies you have, along with the date and type of the reaction you had		

Hospital Admissions (Please start with the most recent)	
Date / Hospital / Reason for hospitalization	Date / Hospital / Reason for hospitalization
1.	4.
2.	5.
3.	6.

Social History

Birthplace: _____ Raised: _____ Resides: _____

Marital Status: _____ Offspring: # of sons _____ # of daughters _____

Offspring Major Medical Problems: _____

Family/Care giver available: Self Other: _____

Education (please check): High School Trade School College Post graduate

Occupational History: _____

Family History (If any blood relative has suffered any of the following please circle the number & indicate which relative)	
1) Alcoholism 6) Cancer 11) Heart Disease 16) Mental Illness	
2) Anemia 7) Diabetes 12) Hepatitis 17) Stroke	
3) Arthritis 8) Epilepsy 13) High Cholesterol 18) Thyroid	
4) Asthma 9) Glaucoma 14) Hypertension 19) Sickle Cell	
5) Bleeds easily 10) Hayfever 15) Migraine 20) Osteoporosis	

Patient Name: _____ **SS#:** _____

Medical History	Please circle if you currently or previously have had any of the following symptoms or diseases		
Dizzy Spells Fainting Spells Decreased hearing Ringing in ear Ear infections Failing vision Eye pain Double/blurred vision Nose bleeds Asthma / Wheezing Bronchitis Chronic Cough Hayfever/allergies Hoarseness Pneumonia Pleurisy Sinus trouble Sore throats- <i>frequent</i> Shortness of breath On exertion Lying flat Chest pain Hypertension Heart Murmur Swelling Palpitations Leg pain Cold numb feet Varicose Veins Phlebitis Deep vein thrombosis	Loss of appetite Difficulty swallowing Heartburn Ulcer Nausea/Vomiting Diarrhea Constipation Abdominal pain Hemorrhoids Bloody or tarry stool Hernia Jaundice/Hepatitis Gall bladder trouble Weight loss Weight gain Anemia Bruise easily Blood transfusions Cancer Diabetes Chronic fatigue Thyroid disease Seizures Stroke Parkinsons Tremors Numbness Headaches Osteoporosis Arthritis Rheumatism	Bone fractures Joint injury Back pain Neck pain Gout Rashes Hives Psoriasis Eczema Hair loss ----Urination----- urgency to urinate Frequency Painful Blood in urine Kidney stones Urine infections Dribbling urine Stress incontinence Sexually transmitted disease Rheumatic fever Scarlet fever Chicken pox Measles Polio Mumps Herpes German Measles Tuberculosis Aids/ HIV --Any type of sleeping difficulty	Depression Anxiety Memory Loss Mental Illness Phobias Suicidal thoughts Moodiness ----- Alcohol ___oz/week Caffeine___cup/day Smoking___cig/day # years_____ year quit_____ Exercise_____ Street drugs_____ Acupuncture Tattoos -----Females----- Menstrual Flow reg. irreg. painful Pain/bleeding during or after sex Date of last menses _____ Menopause_____ Pregnancy#_____ Miscarriage#_____ Abortions#_____ Live births#_____ Birth control_____

Vaccine	Year of last	Test / Exam	Year of last	Test / Exam	Year of last
Tetanus/Td	_____	Rectal/stool	_____	Podiatry	_____
Influenza (FLU)	_____	Cholesterol	_____	Females--	
Pneumonia	_____	Eye exam	_____	Pap smear	_____
Hepatitis	_____	PPD test (T.B.)	_____	Mammogram	_____
		Hearing test	_____	Males--	
		Colonoscopy	_____	PSA	_____
		X-rays	_____	Prostate exam	_____
		CT Scans/MRI	_____		

