Banner Health®

NEW PATIENT MEDICAL HISTORY - ADULT PULMONOLOGY

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Referring Physician

Name: _____ Phone #: _____

Address: _____ Fax #: _____

ALLERGIES

❑ No Known Allergies List any allergies and intolerances to **medications, food or the environment.**

Allergy	Reaction

MEDICATIONS

❑ Not taking any medications

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

Medication Name	Dose	How often?

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(01/2017)

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MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	Alcoholism		Cancer: _____		Hepatitis		Osteoporosis
	Alpha-1 antitrypsin		COPD		High cholesterol		Pneumonia
	Allergies		Coronary artery disease		Histoplasmosis		Prostate enlargement
	Anemia		Crohn's disease		HIV/AIDS		Pulmonary fibrosis
	Angina		Depression		Hypertension		Restless leg syndrome
	Anxiety		Diabetes		Irritable bowel		Sarcoidosis
	Arthritis		Emphysema		Insomnia		Seizure disorder
	Asbestosis		Empyema		Kidney disease		Sleep apnea
	Asthma		Fibromyalgia		Liver Disease		Sleep walking
	Atrial fibrillation		Gallbladder disease		Lung abscess		Stroke
	Blood clots		GERD-reflux		Migraines		Thyroid disease
	Bronchitis		Heart disease		Osteoarthritis		Ulcers

Other medical problems:

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?

Date	Reason	Date	Reason

SURGICAL HISTORY

List all prior surgeries and the year. ❑ **No prior surgeries**

Year	Type of Surgery		Year	Type of Surgery		Year	Type of Surgery
	Angioplasty			Gallbladder removal			Pacemaker
	Angio with stent			Gastric bypass			Prostate biopsy
	Appendectomy			Heart bypass			Thyroidectomy
	Arthroscopy knee			Hernia repair			Tonsillectomy
	Back surgery			Hip replacement			Tubal ligation
	Bowel resection			Hysterectomy			TURP (prostate)
	Carpal Tunnel			Knee replacement			Vasectomy
	Cataract extraction			LASIK			
	Colon removal			Liver biopsy			

Other surgeries:

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FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brothers				
Sisters				

Any Additional Pertinent Family History: _____

_____

SOCIAL HISTORY

Tobacco/smoking status:	❑ Never				
	❑ Current	Type	Amount	Duration	
	❑ Former	Type	Amount	Duration	
Do you use alcohol?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use Caffeine?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use recreational drugs?	❑ No	❑ Yes	Type	Amount	Frequency

Occupation _____ Employer _____

HEALTH MAINTENANCE

List the last date given:

Flu:	Zostavax (Shingles):
Pneumococcal:	

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REVIEW OF SYSTEMS

In the last **thirty days,** have you experienced any of the following:

CONSTITUTIONAL			GENITOURINARY (male)			PSYCHIATRIC		
Chills	Yes	No	Erectile dysfunction	Yes	No	Anxiety	Yes	No
Fatigue	Yes	No	Penile discharge	Yes	No	Depression	Yes	No
Fever	Yes	No	Sexual dysfunction	Yes	No	Insomnia	Yes	No
Malaise	Yes	No	**GENITOURINARY (female)**			**SKIN**		
Night sweats	Yes	No	Abnormal pap	Yes	No	Contact allergies	Yes	No
Weight gain	Yes	No	Breast discharge	Yes	No	Hives	Yes	No
Weight loss	Yes	No	Breast lump	Yes	No	Itching	Yes	No
HEENT			Dysmenorrhea	Yes	No	Mole change	Yes	No
Ear drainage	Yes	No	Hot flashes	Yes	No	Rash	Yes	No
Ear pain	Yes	No	Irregular menses	Yes	No	Skin lesion	Yes	No
Eye discharge	Yes	No	Vaginal discharge	Yes	No	**MUSCULOSKELETAL**		
Eye pain	Yes	No	**METABOLIC/ENDOCRINE**			Back pain	Yes	No
Nasal drainage	Yes	No	Cold intolerance	Yes	No	Joint pain	Yes	No
Sinus pressure	Yes	No	Diabetes	Yes	No	Muscle weakness	Yes	No
Sore throat	Yes	No	Type: _____			Neck pain	Yes	No
Vision changes	Yes	No	Excessive sweating	Yes	No	**HEMATOLOGIC**		
RESPIRATORY			Excessive thirst	Yes	No	Easy bleeding	Yes	No
Chronic cough	Yes	No	Heat intolerance	Yes	No	Easy bruising	Yes	No
Cough	Yes	No	Weight loss	Yes	No	Lymphadenopathy	Yes	No
Known TB exposure	Yes	No	**NEUROLOGICAL**			**IMMUNOLOGIC**		
Shortness of breath	Yes	No	Dizziness	Yes	No	Environmental allergies	Yes	No
Wheezing	Yes	No	Extremity numbness	Yes	No	Food allergies	Yes	No
			Extremity weakness	Yes	No	Seasonal allergies	Yes	No
CARDIOVASCULAR			Gait disturbance	Yes	No			
Chest pain	Yes	No	Headache	Yes	No			
Claudication (pain in extremities)	Yes	No	Memory loss	Yes	No			
Edema (swelling)	Yes	No	Seizures	Yes	No			
Palpitations	Yes	No	Tremors	Yes	No			
GASTROINTESTINAL								
Abdominal pain	Yes	No						
Constipation	Yes	No						
Change in stools	Yes	No						
Frequent diarrhea	Yes	No						
Loss of appetite	Yes	No						
Nausea	Yes	No						
Vomiting	Yes	No						

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SLEEP HISTORY

Please answer the following questions:

Yes	**No**	Do you awaken with choking?		**Yes**	**No**	Do you have dry/sore mouth in the morning?
Yes	**No**	Do you have difficulty concentrating?		**Yes**	**No**	Do you stop breathing at night?
Yes	**No**	Do you have difficulty initiating sleep?		**Yes**	**No**	Do you have restless legs around bedtime?
Yes	**No**	Do you have difficulty maintaining sleep?		**Yes**	**No**	Does your partner complain that you kick at night?
Yes	**No**	Do you experience gasping during sleep?		**Yes**	**No**	Do you toss and turn at night?
Yes	**No**	Do you have morning headaches?		**Yes**	**No**	Do you kick off the covers?
Yes	**No**	Do you have heartburn?		**Yes**	**No**	Do you dream most nights?
Yes	**No**	Are you experiencing increased irritability?		**Yes**	**No**	Do you experience frequent nightmares?
Yes	**No**	Do you have nasal congestion in the morning?		**Yes**	**No**	Do you sleep walk?
Yes	**No**	Do you go to the bathroom at night?		**Yes**	**No**	Do you sleep talk?
Yes	**No**	Do you have non-restorative sleep?		**Yes**	**No**	Do you find it hard to move or speak when you wake up?
Yes	**No**	Have you experienced personality changes?		**Yes**	**No**	Do you find it hard to move or speak when going to sleep?
Yes	**No**	Are you experiencing poor or worsening memory?		**Yes**	**No**	Do you wake up short of breath?
Yes	**No**	Do you have uncontrollable urge to sleep at inappropriate times?		**Yes**	**No**	Are you excessively tired during the day?
Yes	**No**	Do you snore (reported by patient)?		**Yes**	**No**	Do you lose muscle control when you have strong emotions (such as laughing)?
Yes	**No**	Do others report that you snore?		**Yes**	**No**	Do you take naps?
Is your snoring: ❑ mild ❑ moderate ❑ severe ❑ don't snore				If you take naps, do they make you feel: ❑ better ❑ worse		

Please indicate how likely you are to doze off or fall asleep by using the scale below:

0 = Would never dose
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing (Score 0-3)
Sitting and reading	
Watching TV	
Sitting in a public place (e.g. theater, church)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting quietly after lunch without alcohol	
Sitting and talking to someone	
In a car, while stopped for a few minutes in traffic	
Total	

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