

CFPG Patient Medical History Form

Office Use Only

Account	Date	<input type="checkbox"/> Hospital	<input type="checkbox"/> Mills
		<input type="checkbox"/> East	<input type="checkbox"/> North

Please Print

Patient Information

Patient Name: _____ **Age:** _____ **Today's Date:** _____

Current Occupation: _____ **If retired, previous occupation:** _____

Today's Visit

What is the main reason for today's visit, and when did you first notice this problem?

Current Problems

Please check any current problems you are having. If yes, please explain.

- | | | | |
|---|------------------------------|-----------------------------|--------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Hay fever (allergies) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Cough <input type="checkbox"/> with phlegm <input type="checkbox"/> with blood | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Color: _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Sleeping disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Medications

Prescription and non-prescription medicines, vitamins, home remedies, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day

Allergies or reactions to medications: _____

Allergies

Please check any current allergies you have.

- | | | | | |
|---|-------------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> Ace Inhibitors | <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Mold | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Pet Dander | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> X-ray Dye | <input type="checkbox"/> No Known Allergies |

Other Allergies: _____

Immunizations

Date of your most recent IMMUNIZATION: Influenza (flu shot) _____ Pneumovax (pneumonia) _____ Other: _____

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Patient Information

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Testing

Please check any recent testing you had.

Type of Test	When	Where	Results (If Known)
TB Skin Test			
Chest X-ray/CT Scan			
Pulmonary Function Test (PFT)			

Past Surgical/Hospitalization History

Please list all prior operations/hospitalization (with dates).

Type of Surgery/Hospitalization	Where (e.g. name of hospital or facility)	Date

Past Medical History

Please check if you have ever been diagnosed with any of the following.

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspirations | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchiectasis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> Cardiac Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fissure | <input type="checkbox"/> GERD/Heart Burn |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hodgkin's Disease |
| <input type="checkbox"/> Hyperactive Airway | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Non-Hodgkin's Lymphoma | <input type="checkbox"/> Obesity | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pneumothorax | <input type="checkbox"/> Pulmonary Emboli |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Raynaud's Phenomenon | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Condition |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Stridor | <input type="checkbox"/> Stroke, TIA, CVA | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other: _____ | | | |

Exposures

Have you ever been exposed to any of the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> asbestos | <input type="checkbox"/> carpenter's wood dust | <input type="checkbox"/> dust | <input type="checkbox"/> radiation |
| <input type="checkbox"/> ammonia | <input type="checkbox"/> chemical/toxin | <input type="checkbox"/> feathers | <input type="checkbox"/> silica |
| <input type="checkbox"/> agent orange | <input type="checkbox"/> chemical fumes or gases | <input type="checkbox"/> fiberglass | <input type="checkbox"/> soldering/welding |
| <input type="checkbox"/> animals/pets | <input type="checkbox"/> chlorine | <input type="checkbox"/> mold growing in house | <input type="checkbox"/> tobacco exposure |
| <input type="checkbox"/> burns wood in home | <input type="checkbox"/> coal dust | <input type="checkbox"/> oil or kerosene burning heater in home | <input type="checkbox"/> UV overexposure |

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Patient Information

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Family History

Please indicate the current status of your immediate family members. Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

Addison's disease	_____	High cholesterol	_____
Alcoholism	_____	Hypertension	_____
Alzheimer's disease	_____	Kidney disease	_____
Asthma	_____	Lupus	_____
Autoimmune disorder	_____	Obesity	_____
Cancer (list type)	_____	Osteoporosis	_____
Cardiovascular	_____	Respiratory disease	_____
COPD	_____	Rheumatoid arthritis	_____
Cystic fibrosis	_____	Schizophrenia	_____
Diabetes	_____	Sickle cell disease	_____
Emphysema	_____	Stroke	_____
Fibromyalgia	_____	Thyroid disease	_____
Heart problems	_____	Tuberculosis	_____
Hepatitis	_____	Other:	_____

Tobacco Use

Cigarettes:

- Never Smoked
- Former Smoker: Quit Date _____ . Packs per day _____ for _____ number of years
- Current Every Day Smoker. Packs per day _____ for _____ number of years
- Current Some Day Smoker. Packs per day _____ for _____ number of years
- Current Status Unknown

Other tobacco: Pipe Cigar Snuff Chew

Are you interested in quitting? Yes No

Alcohol Use

Do you drink alcohol? Yes, number of drinks/week _____ No

Drug Use

Do you use recreational drugs? Yes No

Caffeine Use

Do you drink/use caffeine (Coffee/tea/soda)? Yes, number of cups/day _____ None