CFPG Patient Medical History Form

Office Use Only		
Account	Date	☐Hospital ☐Mills ☐East ☐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.

- ☐ Shortness of breath ☐ Yes ☐ No ______________
- ☐ Wheezing ☐ Yes ☐ No ______________
- ☐ Hay fever (allergies) ☐ Yes ☐ No ______________
- ☐ Cough ☐ with phlegm ☐ with blood ☐ Yes ☐ No Color: ______________
- ☐ Fevers ☐ Yes ☐ No ______________
- ☐ Recent weight change ☐ Yes ☐ No ______________
- ☐ Sleeping disorder ☐ Yes ☐ No ______________
- ☐ Difficulty swallowing ☐ Yes ☐ No ______________
- ☐ Chest pain ☐ Yes ☐ 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.

- ☐ Ace Inhibitors ☐ Anesthesia ☐ Antihistamines ☐ Aspirin ☐ Codeine
- ☐ Dairy Products ☐ Iodine ☐ Latex ☐ Mold ☐ Penicillin
- ☐ Pet Dander ☐ Prednisone ☐ Sulfa Drugs ☐ X-ray Dye ☐ 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.

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

Exposures

Have you ever been exposed to any of the following?

- ☐ asbestos
- ☐ ammonia
- ☐ agent orange
- ☐ animals/pets
- ☐ burns wood in home
- ☐ carpenter's wood dust
- ☐ chemical/toxin
- ☐ chemical fumes or gases
- ☐ chlorine
- ☐ coal dust
- ☐ dust
- ☐ feathers
- ☐ fiberglass
- ☐ mold growing in house
- ☐ oil or kerosene burning heater in home
- ☐ radiation
- ☐ silica
- ☐ soldering/welding
- ☐ tobacco exposure
- ☐ 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