Medical History for Heart and Lung Patients

Name_____ Date_____

Date of Birth _____ Age _____ Place of Birth _____

Years in Arizona _____ Occupation _____

Present Medical Complaints and Date of Onset _____

_____

_____

Past History: Circle the following infectious diseases you have had. Please give age of onset.

Chicken Pox _____	Polio_____	Tonsillitis _____	Encephalitis _____
Diabetes_____	Rheumatic Fever_____	Pleurisy_____	Syphilis _____
Measles _____	Mono _____	Scarlet Fever _____	Gonorrhea _____
Mumps_____	Influenza _____	Hepatitis _____	Valley Fever _____
TB_____	Pneumonia_____	Meningitis _____	Other_____
Whooping Cough _____	Infectious Mono _____	AIDS _____	_____
Malaria _____	Diphtheria _____	St. Vitus Dance _____	_____

Surgeries and ALL Major Injuries or Illnesses you have been hospitalized for:

TYPE	DATE	HOSPITAL	SURGEON

Please list ALL Medications you are presently taking on a regular basis:

MEDICATION	DOSE	HOW OFTEN

Are you allergic to any medications or foods? YES NO (if yes, please list below)

_____

_____

_____

Do you smoke? ☐YES ☐NO Age started_____Age stopped_____Cigarettes per day_____
Do you drink alcohol? ☐YES ☐NO Type and Amount_____
Number of cups of coffee each day _____ TEA _____ COLA _____

CARDIORESPRIATORY: Please check each question YES or NO

☐YES ☐ NO DATE OF ONSET DESCRIBE

Chest pain/tightness_____
Chronic Cough_____
Blood Streaked Sputum_____
Shortness of Breath_____
Wheezing_____
Heart Mumur_____
Palpitations_____
High Blood Pressure_____
Low Blood Pressure_____
Swelling (hands, feet, etc) _____
Varicose Veins_____
Blood Clots_____

Family History: ALIVE DECEASED AGE Present Health/Cause of Death
Mother: _____
Father: _____
Brothers: _____
Sisters: _____

Have you had any of the following?

☐ YES ☐ NO Date of last exam Where Results

Chest X-Ray_____
EKG_____
TB Skin Test _____
Valley Fever Test _____