Patient No._____

PATIENT'S PERSONAL HISTORY

Date_____

Confidential Record Information contained here will not be released except when you have authorized us to do so.

Last Name First Middle

_____

Address City / State Zip Code

_____

Referring Physician:

_____

Describe briefly your present medical symptoms:

_____

_____

_____

_____

DRUG ALLERGIES_____

Please list current medications:

_____

_____

_____

_____

List previous surgeries:

_____

_____

_____

List diseases you have had which required hospitalization:

_____

_____

_____

_____

List other illnesses (not requiring hospitalization):

_____

_____

_____

List childhood illnesses:

_____

_____

_____

Yes No Have you had a TB skin test? When?_____ (circle) Positive / Negative

Yes No Have you been exposed to anyone with tuberculosis?

Yes No Do you have any pets?_____

Yes No Have you ever had a blood transfusion?

Yes No Have you previously traveled overseas?

Where?_____ How long?_____

PREVIOUS VACCINATIONS:

Yes No Measles

Yes No Mumps

Yes No Rubella

Yes No Tetanus - How long since last booster?_____

Yes No Diphtheria

Yes No Hepatitus

Yes No Pneumonia (Pneumovax)

Yes No Do you receive annual flu vaccines?

OPERSONAL HABITS: (circle)

Yes No Do you smoke? Cigarettes ❒ Packs per day____Pipe ❒ Cigars ❒ For how many years?____

If you used to smoke: How long did you smoke?_____

How many years did you smoke?_____

Yes No Do you drink alcohol If so, how much?_____

Yes No Have you ever used IV drugs?

OCCUPATIONAL HISTORY: (give job descriptions of past and present jobs)

_____

_____

_____

_____

_____

_____

Yes No Have you ever been exposed to (circle): Asbestos / Coal dust / Silica?

Hobbies: _____

_____

_____

_____

FAMILY HISTORY	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Brother/Sister (circle sex)					
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Son/Daughter (circle sex)					
	M F				
	M F				
	M F				
	M F				

*Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter

Do you know any blood relative who has or had: (Circle and give relationship)

Stroke	_____	Leukemia	_____	Cancer (? type)	_____
Heart Attack	_____	Asthma	_____	Emphysema	_____
High Blood Pressure	_____	Kidney Disease	_____	Others	_____
Diabetes	_____	Others	_____		_____

REVIEW OF SYSTEMS

GENERAL

Yes No Are you having fatigue?

Yes No Have you had recent weight (circle) gain / loss? How much? (pounds)_____

Yes No Are you having headaches? (If so, describe) _____

_____

Yes No Earache?

Yes No Hearing Loss?

Yes No Visual problems not connected with glasses?

Yes No Sinus Congestion or postnasal drip?

SLEEP

Yes No Have you ever been told you (circle): Snore / Stop breathing during sleep?

Yes No Have trouble getting to sleep?

Yes No Feel rested in the morning?

Yes No Excessive daytime sleepiness?

RESPIRATORY

Yes No Shortness of breath? If so, (circle) at rest / with activity / both

Yes No Wheeze?

Yes No Cough?

CARDIAC

Yes No Do you have palpitations?

Yes No Do you have chest pain?

Yes No If so, how long does each episode last?_____ with (circle): Rest / Activity / Both

Yes No Is chest pain associated with (circle): nausea / sweating / shortness of breath?

Yes No Does chest pain radiate: across chest / down arm / up neck?

GI

Yes No Diarrhea

Yes No Alternating diarrhea with constipation

Yes No Constipation

Yes No Blood in stool or dark black stools

Yes No Abdominal pain

Yes No Reflux of stomach acid and/or indigestion

GU

Yes No Blood in urine

Yes No Pain or Burning

Yes No Loss of Bladder control

To be answered by WOMEN only: (circle)

Yes No Are you still having menstrual periods? Date of last menstrual period_____

Yes No Are you having bleeding between your periods?

Yes No Do you perform self breast exams?

Date of last Pap Smear _____

Date of last Mammogram _____

Date of last Breast exam _____

To be answered by MEN only: (circle)

Yes No Loss of sexual activity? For how long?_____

Yes No Discharge from penis?

Yes No Trouble urinating?

MUSCULOSKELETAL

Yes No Any muscle or joints aches? (If so, where?):_____

NEUROLOGICAL

Yes No Numbness or weakness in one arm or one leg?

Yes No Dizziness or light-headedness?

PSYCHIATRIC

Yes No Anxiety?

Yes No Depression?

SKIN

Yes No Itching and/or rash? If so, please describe:_____

PULMONARY ASSOCIATES OF THE SOUTHEAST, P.C.

Trinity Medical Center
880 Montclair Rd. Ste 270
Birmingham, Al 35213

St. Vincent's Blount
150 Gilbreath Drive
Oneonta, AL 35121

(205) 802-2000
(205) 802-2012 fax
1-866-887-5864

Authorization to Discuss Personal Health and Billing Information

Please list 2 family members or others that we may talk to about your medical records and/or billing information: *This is not to include* the patient or other physicians.

_____

(name and phone number)

_____

(name and phone number)

Receipt of Notice of Privacy Practices

Pulmonary Associates of the Southeast, P.C. has made available to me their Notice of Privacy Practices.

_____

Patient

_____

Date