PENN JERSEY PULMONARY ASSOCIATES
PATIENT MEDICAL HISTORY INFORMATION

NAME____________________________________**BIRTH DATE**____________________

Referred by Dr.____________________________Today's Date______________________

Reason for Visit____

Have you ever had any of these Pulmonary Complaints or Conditions?
(If yes, place √ mark next to it)

____Shortness of Breath ____Sinus Drip ____Bronchitis
____Wheezing ____Sinus Infection ____Emphysema
____Cough ____Seasonal Allergies ____Asthma
____Chest Pains ____Snoring ____ Collapsed Lung
____Exposure to Chemicals____Exposure to Asbestos ____Tuberculosis
____Past Lung Surgery When?______ Describe:_________________________________

Other past medical history:

____High Blood Pressure ____Blood Clot
____Acid Reflux ____Unexplained Weight Loss
____Diabetes ____Bowel or Bladder Problems
____Heart Attack ____Cancer
____Congestive Heart Failure ____Thyroid Disease

Have you ever smoked? ______(yes or no) How many packs per day?______
How many years?________Do you have any second hand smoke exposure?_______

____ **Any recent travel outside of U.S.? Describe**________________________________

Any family history of Lung Disease, Heart Disease, Cancer or Diabetes?
If yes, describe:
Mother ____
Father____
Brothers or Sisters____

List the Medications you are presently taking: (or attach your list)

1.________________________________5.____________________________________
2.________________________________6.____________________________________
3.________________________________7.____________________________________
4.________________________________8.____________________________________

Are you ALLERGIC to any medications? Yes______ No________
List____

Would you like a copy of our report to go to any other doctors (list):

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