Comprehensive Sleep & Pulmonary Practice
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CONFIDENTIAL HEALTH HISTORY

Name: _____Date: _____

Reason for visit:

_____

ALLERGIES:

_____

Please list the symptoms you currently have:

1.
2.
3

Medical History: check ( ) the medical conditions you have or have had in the past.

☐AIDS/HIV	☐Glaucoma	☐Psychiatric Care	☐Wake up short of breath
☐Tonsilitis	☐TB	☐Use of Prednisone	
☐Arthritis	☐Heart Disease	☐Rheumatoid Arthritis	☐Asthma
☐Heart Surgery	☐Reflux	☐Oxygen use	
☐Blood Clots	☐Hepatitis	☐Sarcoidosis	☐
____Leg	☐High BP	☐Sleep Apnea	
____Lung	☐Kidney disease	☐Stroke	☐
☐Bronchitis	☐Liver Disease	☐Thyroid Problems	
☐Cancer	☐Lung Surgery	☐Cough	☐
☐Chem Depend	☐Lupus	☐Cough with phlegm	
☐COPD	☐Narcolepsy	☐Cough with blood	☐
☐Diabetes	☐Pacemaker	☐Snoring	
☐Emphysema	☐Pneumonia	☐Wake up choking	☐

Surgery / Hospitalizations:

Date: Reasons:

_____
_____ _____
_____

Name:_____ Date_____

Family History: (parents, siblings) Specify

☐Cancer _____
☐Asthma _____
☐COPD _____
☐Sleep apnea_____
☐Heart Disease _____
☐High Blood Pressure _____
☐Diabetes _____
☐Stroke _____
☐Blood Clots_____
☐
☐

Social History:
Exposure:
☐ Coal Dust
☐ Dust / Fumes / Chemical
☐ Asbestos - where

Drug Use Yes____ No____
Caffeine Yes____ No____
Alcohol Yes____ No____

Tobacco: Currently smoke **Y/N** Non-smoker **Y/N** Ex-smoker **Y/N**
Average # of packs per day_____# years smoked_____
Age started smoking?_____ Age stopped smoking?_____

Dates of Following:

Flu Vaccine :

Chest X-ray/CT: (where)

P**neumoniaVaccine:**

List of current Medications:

1.

2.

3.

4.

5.