WEST COAST PULMONARY
& SLEEP DISORDERS CENTER

Medical History

Name: ___________________ **Age:** ___ **Birthdate:** __________

Welcome to our office. This questionnaire is intended to help your doctor better understand your needs. If there are any questions you do not understand, please talk them over with us.

Name of doctor who referred you here: _____________________
Name of primary doctor: _____________________
Reason for your visit: ____

Medical Illnesses (please check)

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Valley fever
- ☐ Sleep apnea
- ☐ Pulmonary fibrosis
- ☐ Sinus infections
- ☐ Heart attack
- ☐ Heart failure
- ☐ Atrial fibrillation
- ☐ Colon problem
- ☐ Heartburn/reflux
- ☐ Ulcer
- ☐ Liver disease
- ☐ Cancer
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Blood clot on legs or lungs
- ☐ Epilepsy/seizure
- ☐ Stroke

Other:

Surgeries: __________________________________

Allergies to medications: __________________________________

Medications (include prescription and over-the-counter medicines)

Name	Dosage	How many times a day

Name	Dosage	How many times a day

Immunizations

Date of last flu vaccine (m/d/yy): _____ Date of last pneumonia vaccine: _____

Date of last PPD: _____ Positive or Negative: ___________

Family History

	Medical Problems	Age at Death	Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Child(ren)			

Any other blood relatives with lung problems? ______________________________

Personal History

Birthplace: ____________________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Military service: ☐ Yes ☐ No If yes, where? __________________

Occupation: ___________________

Highest level of school completed: ____________________

Exposed to: ☐ Fumes ☐ Dust ☐ Chemicals ☐ Mold ☐ Asbestos

Pets at home, including birds: __________________

Smoking: ☐ Never smoked

If you did or do smoke, how many years? __________

When did you quit? _________

☐ Cigarettes How many packs per day? _____

☐ Cigars How many per day? _____

☐ Pipe

What treatments have you tried to quit smoking? ____________________

Alcohol: Do you drink alcohol? ☐ Yes ☐ No

Type: ___________________

Ounces per day/week: ____________

Drugs: Have you used any drugs? ☐ Yes ☐ No

Type: ________________________

When did you quit? _________

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Review of Systems (please check)

General
- [ ] Fever
- [ ] Chills
- [ ] Sweats at night
- [ ] Fatigue

Sleep
- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Snoring
- [ ] Excessive daytime sleepiness
- [ ] Sleep apnea
- [ ] Witnessed apneas

Neurological
- [ ] Headaches
- [ ] Seizures
- [ ] Weakness
- [ ] Numbness
- [ ] Depression

Skin
- [ ] Rash
- [ ] Itching
- [ ] Loss of hair

Eyes
- [ ] Change in vision
- [ ] Pain in eyes
- [ ] Cataracts

Ears/Nose/Mouth
- [ ] Hard of hearing
- [ ] Runny nose
- [ ] Sinus problems
- [ ] Polyps in nose
- [ ] Sores in mouth
- [ ] Dental problems
- [ ] Hoarseness

Hematologic
- [ ] Anemia
- [ ] Bleeding or bruising easily

Gastrointestinal
- [ ] Lost weight recently
- [ ] Gained weight recently
- [ ] Loss of appetite
- [ ] Stomach pain
- [ ] Heartburn
- [ ] Difficulty swallowing
- [ ] Vomiting
- [ ] Constipation
- [ ] Diarrhea
- [ ] Blood in bowel movement
- [ ] Jaundice

Pulmonary
- [ ] Wheezing
- [ ] Coughing
- [ ] Phlegm
- [ ] Bloody phlegm
- [ ] Hoarse voice
- [ ] Shortness of breath

Cardiac
- [ ] Chest pain
- [ ] Palpitations
- [ ] Ankles swollen
- [ ] Wake up short of breath
- [ ] Fainting

Genitourinary
- [ ] Pain when urinating
- [ ] Frequent urination
- [ ] Blood in urine
- [ ] Kidney stones
- [ ] Trouble starting urine
- [ ] Nighttime urination
- [ ] Prostate problem

Bones/Joints
- [ ] Joints painful or swollen
- [ ] Muscle cramps
- [ ] Arthritis
- [ ] Gout
- [ ] Osteoporosis