MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

Name:_____ Date:_____

Date of Birth:_____/_____/_____
Month Day Year

Please describe your current complaint or reason you are seeing the doctor:

_____

_____

When did problem(s) begin? _____

ALLERGIES AND/OR MEDICINE REACTIONS

Do you have allergies or reactions to any medications/substance? Yes_____ No_____

If yes, type of reaction: (ex. Rash, swelling, etc…)
Rx/Substance:_____ Reaction: _____

Rx/Substance:_____ Reaction: _____

Rx/Substance: _____Reaction: _____

Rx/Substance: _____ Reaction: _____

SMOKING/ALCOHOL HISTORY

Have you / Do you Smoke?

Never_____ Currently_____ Past/Quit_____ Date Quit_____

Packs per day_____ Number of years_____

Other:

Pipe:_____ Cigar_____ Snuff____ Chew_____ Marijuana_____ Second Hand Smoke_____

Are you interested in quitting? Yes_____ No_____
Alcohol Consumption: Daily_____ Weekly_____ Monthly_____ Occasionally_____

What is your current activity level: Active_____ Sedentary_____ House Bound _____

Have you traveled outside of the US in the past five years? Yes_____ No_____
(If yes, where)_____

Current Occupation: _____

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<u>HOSPITALIZATION / SURGERIES</u> (NOT LISTED ELSEWHERE) – TYPE AND DATE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Date of your most recent immunizations:
Influenza (Flu): _____ Pneumonia: _____

If you have ever had a listed condition in the past, please check the Past column.
If you are presently troubled by a listed condition, please check the Present column.
If you have not experienced a problem, please check never.

	Past	Present	Never	
Cough	☐	☐	☐	Productive: Yes___ No_____ Color:_____ Blood in Sputum: Yes____ No____
Shortness of breath	☐	☐	☐	When: Activity_____ At Rest_____ Wakes up at Night_____
Wheezing	☐	☐	☐	With Activity_____ Worse at Night_____
Lung Disease	☐	☐	☐	Emphysema_____ Asthma_____ Chronic Bronchitis_____ COPD_____
Heart Disease	☐	☐	☐	Heart Attack_____ CHF_____ Palpations_____ Irregular Rhythm_____
Sinus/Nasal Problems	☐	☐	☐	Drainage_____ Color_____ Congestion_____
High Blood Pressure	☐	☐	☐	
Stroke	☐	☐	☐	
Pain	☐	☐	☐	Location_____
Cancer	☐	☐	☐	Location:_____ When:_____
Diabetes	☐	☐	☐	Insulin_____ Oral Medicines_____ Diet Controlled_____
Arthritis	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Congenital Disease	☐	☐	☐	
Immune Disease	☐	☐	☐	
Seizures	☐	☐	☐	
Headaches	☐	☐	☐	When: Any Time of Day_____ Morning_____ Evening_____
Weight Gain	☐	☐	☐	
Weight/loss	☐	☐	☐	
Depression	☐	☐	☐	
Anxiety	☐	☐	☐	
Sleep Problem	☐	☐	☐	Snoring_____ Gasping for Breath_____ Insomnia_____
Restless Legs	☐	☐	☐	During the Day_____ Worse at Night: Yes_____ No_____
Blood Clots	☐	☐	☐	Location: _____ When: _____
Dizziness	☐	☐	☐	
Abnormal Chest X-Ray	☐	☐	☐	Location: _____ When:_____
Other	☐	☐	☐	_____

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FAMILY HISTORY

Father: Alive_____ Deceased_____ Cause_____
Grandfather: Alive_____ Deceased_____ Cause_____
Grandmother Alive_____ Deceased_____ Cause_____

Mother: Alive_____ Deceased_____ Cause_____
Grandfather: Alive_____ Deceased_____ Cause_____
Grandmother: Alive_____ Deceased_____ Cause_____

LIST OF CURRENT MEDICIATIONS

NAME OF MEDICATION	STRENGTH	TIMES PER DAY	REASON/USED TO TREAT

OTHER CONCERNS/INFORMATION