

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? _____ Are complaints work related: Yes _____ No _____

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 Exposure: Past _____ Present _____ Occupational _____

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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HOSPITALIZATION / SURGERIES (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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productive: Yes___ No___ Color:_____ Blood in Sputum: Yes___ No___
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When: Activity_____ At Rest_____ Wakes up at Night_____
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With Activity_____ Worse at Night_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema_____ Asthma_____ Chronic Bronchitis_____ COPD_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack_____ CHF_____ Palpitations_____ Irregular Rhythm_____
Sinus/Nasal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drainage_____ Color_____ Congestion_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location:_____ When:_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin_____ Oral Medicines_____ Diet Controlled_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Congenital Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When: Any Time of Day_____ Morning_____ Evening_____
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring_____ Gasping for Breath_____ Insomnia_____
Restless Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During the Day_____ Worse at Night: Yes___ No___
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location:_____ When:_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location:_____ When:_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

