Please answer a few questions about your health and bring this form with you at the time of the visit.

Reason for pulmonary consultation:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

My past medical problems include:                                     My past surgical procedures include:
1. __________________________                   1. __________________________
2. __________________________                       2. __________________________
3. __________________________                       3. __________________________
4. __________________________                       4. __________________________
5. __________________________                       5. __________________________
6.                                                                                       6. __________________________
7.                                                                                       7. __________________________

I am currently taking the following medications (please include dosage and bring prescription bottles & inhalers with you at the time of your visit:
1. __________________________                   8. __________________________
2. __________________________                      9. __________________________
3. __________________________                     10. __________________________
4. __________________________                     11. __________________________
5. __________________________                     12. __________________________

Are you allergic to any medicines?   □ Yes   □ No

If yes, please list?   _____________________________________________
________________________________________________________________________

I have had the following hospitalizations (include problem, hospital, dates):
1.________________________________________________________________________
2.________________________________________________________________________
3.________________________________________________________________________
4.________________________________________________________________________

The following diseases have occurred in my immediate family members (grandparents, parents, brothers, sisters, children):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Smoking History: □ Yes   □ Occasionally   □ Never
If yes, # of years smoked? ______
# of Packs per day? ______

Occupation & Work Environment:  _________________________________________________________________________
______________________________________________________________________________________________________

Social History: □ Married □ Single □ Separated □ Divorced
Children: □ Yes, # of Children ______   □ No