PHYSICIAN PARTNERS
PULMONARY, CRITICAL CARE, SLEEP SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Reason for today's visit?_____

Please check any of the following health problems you have had or have now:

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke (or Mini-Stroke)
[ ] Asthma
[ ] COPD or Emphysema
[ ] Obstructive Sleep Apnea
[ ] Coronary Artery Disease
[ ] Congestive Heart Failure
[ ] Atrial Fibrillation
[ ] Chronic Sinus Problems
[ ] Glaucoma
[ ] Pneumonia
[ ] Depression/Anxiety
[ ] Gastric Reflux
[ ] Liver Disease
[ ] Kidney Disease
[ ] Prostate Problems
[ ] Hepatitis
[ ] Bleeding/Clotting Problems
[ ] Abnormal Heart Rhythm
[ ] Thyroid Disease
[ ] Seizure Disorder
[ ] Chronic Pain
[ ] Sleep Disorder
[ ] Bipolar Disease
[ ] HIV/AIDS
[ ] Diabetes
[ ] Cancer _____
[ ] Anemia
Other: _____

List Operations or Procedures and when?

Year	Surgery	Year	Surgery

Family History: Please check the following health problems that have affected your family and identify their relationship to you, ie: Mother, father, grandparent, sibling, child.

[ ] Adopted
[ ] Blood Clots _____
[ ] Bleeding Problems _____
[ ] High Blood Pressure _____
[ ] High Cholesterol _____
[ ] Thyroid Problems _____
[ ] Heart Attack _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Lung Disease _____
[ ] Asthma _____
[ ] Dialysis _____

Have you used tobacco? [ ] No [ ] Yes; If yes, packs/ day: _____ Year Quit: _____

Do you drink alcohol? [ ]No [ ]Yes; If yes, drinks per day _____ Per week: _____

Do you use recreational drugs? [ ]No [ ]Yes; If yes , describe: _____

Have you worked with asbestos products? [ ] No [ ] Yes; If yes, describe the job _____

Have you been exposed to tuberculosis? [ ] No [ ] Yes; If yes, please describe _____

Last PPD Date; _____ Results: [ ] Normal [ ] Abnormal