Health History Intake Form

Pulmonary Associates of Stamford

Name_____ Date of birth _____ Today's date _____

Primary Medical Doctor _____

Surgical history

Procedure	✓ if done	Dx code
Lobectomy		32480
Pneumonectomy		32440
Thoracentesis		32421
Bronchoscopy		31625
CABG (bypass)		35501
Valve surgery		33405
Pacemaker insertion		33208
Coronary stenting		92980
Colon resection		44140
Gall bladder removal		47600
Appendectomy		44950
Hysterectomy		58150
Hernia repair		00750
Cataract removal		66982

Procedure	✓ if done	Dx code
Laminectomy - cervical		63020
Laminectomy - lumbar		22630
Thyroidectomy		60210
Knee surgery		01380
Hip replacement		01210
TURP		52601
Prostatectomy		00914
Breast resection		19125
UPPP		42145
VATS		32098
Tonsillectomy		42825
Adenoidectomy		42830
OTHER		

Vaccines (✓ if received)

☐ **Flu shot** (date):

☐ **Pneumovax** "pneumonia shot" (date):

☐ **Other vaccine in the last 10 years** (name, date):

Allergies (✓ type of reaction or reactions)

Medication	Anaphylaxis	Hives	Itching	Nausea	Rash	Other/ severe	Other/ mild
Penicillin (example)		✓		✓			

Past medical history ✓ for current or former significant health problems

Condition	✓	Notes
PULMONARY		
Asthma		
Emphysema		
Chronic bronchitis		
COPD		
Pulmonary fibrosis		
Sarcoidosis		
Lung cancer		
Tuberculosis		
Sleep apnea		
NON-PULMONARY		
High blood pressure		
High cholesterol		
Diabetes		
Heart attack		
Congestive heart failure		
Atrial fibrillation		
Stroke		
Cancer		
Hypothyroidism		
Hyperthyroidism		
Anemia		
Ulcers		
Gastroesophageal reflux		
Liver disease		
Colitis		
Leg circulation disorders		
Osteoarthritis		
Rheumatoid arthritis		
Migraines		
Depression		
Angioedema		
Urticaria		
Rash		
Rhinitis		
Post Nasal Drip		
Sinusitis		
Obesity		
Other		

Social history

Smoking status	Please circle one: Current	Former	Never

Smoking quantity	Number	Packs per day	or Number	Packs per week

Smoking: how many years?		(number)
Smoking: what age did you start?		(age)
Passive smoke exposure		(yes or no)

Alcohol consumption	Please circle one: None	Occasional	Moderate	Heavy

Alcohol consumption	Number	Drinks per day	or Number	Drinks per week

Caffeine consumption	Please circle one: None	Occasional	Moderate	Heavy

Illicit drugs (list)	

Are you currently employed?		(yes or no)

Occupation (current, former)	
Occupational health risks	

Animals at home		

Marital status	Please circle one: Single	Married	Widowed	Divorced	Separated	Domestic partner

Travel outside New England in last 2 years?	Where?

Country of origin (if not U.S.)		Year of emigration to U.S.	

Do you have an advance directive?		(yes or no)

Family history

Relation	Health problem(s)
Father	
Mother	
Sister	
Sister	
Sister	
Brother	
Brother	
Brother	
Son	
Son	
Daughter	
Daughter	
Other	

Current Medications

Height: **Weight:**

Usual Pharmacy:

Review of Systems

Please indicate IMPORTANT problems from the last few months with a ✓

Constitutional	
Fevers	
Night sweats	
Significant weight gain	
Significant weight loss	
Exercise intolerance	

Genitourinary	
Incontinence	
Difficulty urinating	
Blood in urine	
Awaken to urinate overnight	

Ear/Nose/Throat	
Difficulty hearing	
Frequent nosebleeds	
Nose/Sinus problems	
Sore throat	
Hoarseness	

Musculoskeletal	
Muscle Aches	
Joint Pains	
Back Pain	

Cardiovascular	
Chest pain	
Shortness of breath lying down	
Palpitations	
Heart murmur	
Leg swelling	

Neurologic	
Loss of consciousness	
Seizures	
Dizziness	
Headaches	

Psychiatric	
Depression	
Anxiety	

Respiratory	
Cough	
Wheeze	
Phlegm/Sputum	
Shortness of breath	
Coughing up blood	

Allergy	
Sinus pressure	
Itching	
Hives	
Rash	

Gastrointestinal	
Abdominal pain	
Vomiting	
Change in appetite	
Diarrhea	

Sleep	
Stop breathing at night	
Excessive daytime sleepiness	
Loud snoring	
Sleep is not restorative	