**Patient History Form**

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the major reason for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History**

 Birthplace\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Occupations \_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_Disabled\_\_\_\_\_\_\_ Street Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recreation/Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Exercise\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pets \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tobacco \_\_\_\_How Long­­­\_\_\_ Packs Per Day­­\_\_\_

 Tea, Soda, Coffee\_\_\_\_\_\_\_\_\_\_\_

Traveling outside the country­­­­ \_\_\_\_­­­­When­­­\_\_\_\_\_\_\_\_\_\_

Exposure to Toxic Chemicals (Radiation, Chemo, Asbestos, Other) ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

*Have you had any of the following?* ***Circle those which apply and give dates*** *where appropriate.*

 Measles/Mumps Hay fever/sinusitis

 Whooping Cough Polio

 Scarlet fever Diphtheria

 Meningitis Infectious Mono

 Valley Fever Tuberculosis Exposure to TB Skin test positive to TB

 Malaria Hives

 Pneumonia Bronchitis

 Pleurisy Asthma

 Emphysema Rheumatic Fever

 Arthritis Back Trouble

 Cancer Type\_\_\_\_\_\_\_\_\_\_\_\_\_

 Venereal disease Glaucoma

 High blood pressure COPD

 Heart disease OSA

 Heart attack/Stroke Asthma-Age­\_\_\_

 Diabetes Juvenile Emphysema

 Diabetes adult onset Chronic Bronchitis

 Narcolepsy Pulmonary Fibrosis

 Seizure Lung Cancer

 Anemia Cystic Fibrosis

 Bleeding Tendency Blood transfusion

 Hepatitis (yellow jaundice) Nose bleeds

 Hemorrhoids Ulcer

 Bladder infections Kidney disease

**Surgical History**

*Have you had any of the following operations?* ***Circle those which apply and give dates*** *where appropriate.*

 Heart/Cath/Stent/Pacemaker

 Coronary bypass surgery

 Heart valve replacement

 Tonsils

 Appendix

 Gall bladder

 Stomach

 Breast

 Uterus and /or ovary

 Prostate

 Hernia

 Thyroid

 Varicose

 Veins

 Hemorrhoids

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Injury History**

*Have you had any of the following injuries****? Circle those which apply and give dates*** *where appropriate.*

 Head

 Chest

 Abdomen

 Broken Bones

 Back

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

*Have you had allergies to any of the following?* ***Circle or complete which apply***

 Tetanus antitoxin

 Penicillin

 Sulfa

 Other drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Foods

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations**

*Have you had the following immunizations?* ***Circle those which apply and give dates*** *where appropriate.*

 Smallpox

 Tetanus

 Polio

 Flu shot

 Pneumovax

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

*Do you have a family history of any of the following medical conditions?* ***Circle those which apply and list relationship.***

 Anemia COPD­­

 Bleeding Tendency OSA

 Leukemia Asthma

 Repeated infections Pulmonary Fibrosis

 Crippling infections Cystic Fibrosis

 Heart disease Lung Cancer

 Chronic lung disease Emphysema

 Tuberculosis Chronic Bronchitis

 High blood pressure Narcolepsy

 Kidney disease Diabetes

 Asthma Severe allergies

 Mental illness Gout

 Convulsions Obesity

 Migraine headaches Thyroid trouble

 Peptic ulcer Chronic diarrhea

 Cancer

Father  Alive  Deceased Age \_\_\_\_\_\_

 Causes of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mother  Alive  Deceased Age \_\_\_\_\_\_

 Causes of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Systems Review**

*Have you recently had the following?*

**General Yes No**

 Tire easily [ ]  [ ]

 Weakness [ ]  [ ]

 Night sweats [ ]  [ ]

 Persistent fever [ ]  [ ]

 Sensitivity to heat [ ]  [ ]

 Sensitivity to cold [ ]  [ ]

 Weight Loss [ ]  [ ]

 Weight Gain [ ]  [ ]

**Skin**

 Rash [ ]  [ ]

 Change in color [ ]  [ ]

 Change in hair [ ]  [ ]

 Change in nails [ ]  [ ]

**Eyes Yes No**

 Trouble seeing [ ]  [ ]

 Eye pain [ ]  [ ]

 Inflamed eyes [ ]  [ ]

 Double vision [ ]  [ ]

 Worn glasses [ ]  [ ]

**Ears**

 Loss of hearing [ ]  [ ]

 Ringing in ears [ ]  [ ]

 Discharge from ears [ ]  [ ]

**Nose**

 Loss of smell [ ]  [ ]

 Frequent colds [ ]  [ ]

 Obstruction [ ]  [ ]

 Excess discharge [ ]  [ ]

 Nosebleeds [ ]  [ ]

**Mouth**

 Sore gums [ ]  [ ]

 Soreness of tongue [ ]  [ ]

 Dental problems [ ]  [ ]

**Throat**

 Postnasal drainage [ ]  [ ]

 Soreness [ ]  [ ]

 Hoarseness [ ]  [ ]

 Change in voice [ ]  [ ]

**Breasts**

 Lumps [ ]  [ ]

 Discharge [ ]  [ ]

**Heart**

 Chest pain [ ]  [ ]

 Palpitations [ ]  [ ]

 Short of breath while lying [ ]  [ ]

 High blood pressure [ ]  [ ]

 Vein problems [ ]  [ ]

**Lungs**

 Cough [ ]  [ ]

 Sputum (phlegm) [ ]  [ ]

 Bloody sputum [ ]  [ ]

 Wheezing [ ]  [ ]

 Pain on breathing in chest [ ]  [ ]

 Shortness of breath [ ]  [ ]

 SOB with exertion [ ]  [ ]

 Swelling in ankles [ ]  [ ]

 Bluish fingers or lips [ ]  [ ]

**Abdomen** **Yes No**

 Change in appetite [ ]  [ ]  Difficulty in swallowing [ ]  [ ]

 Heartburn [ ]  [ ]

 Belching [ ]  [ ]

 Excess gas [ ]  [ ]

 Enlargement [ ]  [ ]

 Nausea/Vomiting [ ]  [ ]

 Vomiting blood [ ]  [ ]

 Rectal bleeding [ ]  [ ]

 Bloody stools [ ]  [ ]

 Dark urine [ ]  [ ]

 Jaundice [ ]  [ ]

 Constipation [ ]  [ ]

 Diarrhea [ ]  [ ]

 Hemorrhoids [ ]  [ ]

 Need for laxatives [ ]  [ ]

## Kidney and Urinary

 Increase in urination at night [ ]  [ ]

 Unable to hold urine [ ]  [ ]

 Impotence [ ]  [ ]

 Lack of sex drive [ ]  [ ]

 Pain with intercourse [ ]  [ ]

**Endocrine**

 Thyroid nodule or mass [ ]  [ ]

 High thyroid level [ ]  [ ]

 Low thyroid level [ ]  [ ]

 Adrenal trouble [ ]  [ ]

 High blood sugars [ ]  [ ]

 Low blood sugars [ ]  [ ]

**Muscular**

 Muscle cramps [ ]  [ ]

 Muscle weakness [ ]  [ ]

 Pain in joints [ ]  [ ]

 Swollen joints [ ]  [ ]

 Joint stiffness [ ]  [ ]

 Deformity of joints [ ]  [ ]

**Nervous System**

 Headaches [ ]  [ ]

 Dizziness [ ]  [ ]

 Fainting [ ]  [ ]

 Convulsions or seizures [ ]  [ ]

 Nervousness [ ]  [ ]

 Depression [ ]  [ ]

 Change in sensation [ ]  [ ]

 Memory loss [ ]  [ ]

 Poor coordination [ ]  [ ]

 Weakness [ ]  [ ]

 Paralysis [ ]  [ ]

**Sleep Disorders Yes No**

 Snoring [ ]  [ ]

 Excessive daytime sleepiness [ ]  [ ]

 Pauses in breathing during sleep [ ]  [ ]

 Insomnia [ ]  [ ]

 Sleeplessness [ ]  [ ]

 Sleepiness while driving [ ]  [ ]

**Gyn-OB**

 Pregnant\_\_\_\_\_\_\_\_\_