

# SOUTH BAY RESPIRATORY ASSOCIATES

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## CONFIDENTIAL MEDICAL HISTORY

This questionnaire will help your doctor understand more about you and your medical problems.

Name \_\_\_\_\_

Number \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Age \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE ANSWER EACH QUESTION AS CORRECTLY AS YOU CAN BY PLACING AN "X" IN APPROPRIATE BOX**

WHAT IS THE MAIN REASON YOU ARE HAVING THIS EXAMINATION?

- (1) You are feeling ill or want medical advice. Describe your problem(s):
- (2) Checkup - No Special Complaints

IN THE LAST 3 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS:

	Yes	No		Yes	No
Frequent or severe headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands .....	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells or blackouts .....	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss (more than 5 lbs. in 3 months) .....	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with your eyes or double vision .....	<input type="checkbox"/>	<input type="checkbox"/>	Increased thirst or urination .....	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with your ears .....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies such as hay fever or asthma .....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent hoarseness .....	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash or changes in a mole .....	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough .....	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
Coughing blood .....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Trouble breathing or shortness of breath .....	<input type="checkbox"/>	<input type="checkbox"/>			
Heart trouble .....	<input type="checkbox"/>	<input type="checkbox"/>			
Chest pain or pressure .....	<input type="checkbox"/>	<input type="checkbox"/>			
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>			
Trouble swallowing .....	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal or stomach pain .....	<input type="checkbox"/>	<input type="checkbox"/>			
Blood in bowel movement .....	<input type="checkbox"/>	<input type="checkbox"/>			
Change in bowel habits .....	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea, frequent .....	<input type="checkbox"/>	<input type="checkbox"/>			
Nausea or vomiting, frequent .....	<input type="checkbox"/>	<input type="checkbox"/>			
Tired or rundown .....	<input type="checkbox"/>	<input type="checkbox"/>			
Nervous, depressed or emotional trouble .....	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty with urination .....	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney trouble or infections .....	<input type="checkbox"/>	<input type="checkbox"/>			
Blood in urine .....	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in legs which forces you to stop walking .....	<input type="checkbox"/>	<input type="checkbox"/>			
Pain or swelling in your joints .....	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid trouble (goiter or swelling) .....	<input type="checkbox"/>	<input type="checkbox"/>			

CHECK HERE  IF NONE OF THE ABOVE

FOR WOMEN ONLY		Yes	No
Bleeding between periods .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding, although you no longer have regular periods .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menopause .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge with burning or itching. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lump in breast not previously operated on ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge or blood from your nipples .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you now pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many children do you have? _____			
How many miscarriages or abortions? _____			
Do you take birth control pills? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use other types of birth control? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type? _____			
Are you still having menstrual periods? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was your last period? _____			
If no, what age did they stop? _____			
Did your mother take hormones when she was pregnant with you? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When did you have your last pap test? _____			

Do you have difficulty sleeping? .....  **Yes**  **No**

Are you concerned that you may be at risk for developing sexually transmitted diseases? .....

Do you have a loss of sexual interest or difficulty in performance that concerns you? .....

In the past year have you often found that your worries made you feel sick a lot? .....

In the past year has there been a death in your immediate family? .....

Are you now receiving care from a psychologist or psychiatrist? .....

IN THE PAST YEAR HAVE YOU HAD ANY SERIOUS ILLNESS, SURGERY OR INJURY? .....  **Yes**  **No**

If yes, describe \_\_\_\_\_

IN THE PAST YEAR HAVE YOU BEEN HOSPITALIZED? .....  **Yes**  **No**

If yes, when and reason for hospitalization \_\_\_\_\_

HAVE YOU EVER HAD ANY RADIATION TREATMENT OR EXPOSURE? .....  **Yes**  **No**

**MEDICATION HISTORY**

LIST THE SPECIFIC NAME(S) OF THE MEDICATIONS YOU TAKE REGULARLY, THEIR STRENGTH AND HOW OFTEN. REFER TO THE LABEL ON YOUR MEDICINE CONTAINERS IF NECESSARY.

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
1. _____	_____	_____	4. _____	_____	_____
2. _____	_____	_____	5. _____	_____	_____
3. _____	_____	_____	6. _____	_____	_____

WRITE IN THE NAMES OF ANY MEDICINES OR SHOTS TO WHICH YOU HAVE EVER HAD A BAD REACTION OR ALLERGY. IF NONE, PLEASE WRITE "NONE."

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

**PAST MEDICAL HISTORY**

HAS A DOCTOR EVER SAID YOU HAD ANY OF THE DISEASES OR CONDITIONS LISTED BELOW?

	Yes	No		Yes	No
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease (cirrhosis, hepatitis) .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (fits) .....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or duodenal ulcer .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	Colon or bowel disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder stones .....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder infection .....	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (High blood pressure) .....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease (VD) .....	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur as an adult .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or tumor .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease (coronary, infarct or angina) .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Gout .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema of the lungs .....	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis .....	<input type="checkbox"/>	<input type="checkbox"/>
Emotional problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Other (List) _____		
Gallstones or gallbladder problems .....	<input type="checkbox"/>	<input type="checkbox"/>			

CHECK HERE  IF NONE OF THE ABOVE Go to Page 3

**AT THE PRESENT TIME MY HEALTH IS SUCH THAT: (Check only one)**

I cannot do my usual work at all .....

I can work but am limited in amount or kind of work.....

I am not limited in my usual work .....

**OPERATIONS**

	Year
Appendix	_____
Tonsils	_____
Kidney	_____
Colon (large bowel)	_____
Thyroid	_____
Breast	_____
Hernia (rupture)	_____
Prostate	_____
Vasectomy	_____

	Year
Gallbladder	_____
Stomach	_____
Other	_____
Uterus (womb)	_____
Tubal Ligation (tubes tied)	_____
Any other operations? (List)	_____
	_____
	_____

WHEN WAS YOUR LAST IMMUNIZATION FOR TETANUS (Lockjaw)? \_\_\_\_\_

	Yes	No
HAVE YOU RECEIVED PNEUMOVAX VACCINE (to prevent pneumonia)?.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU, IN THE PAST YEAR, HAD CLOSE CONTACT WITH ANYONE WHO HAD TUBERCULOSIS? .....	<input type="checkbox"/>	<input type="checkbox"/>

**FAMILY HISTORY**

IF ANY BLOOD RELATIVES HAVE HAD ANY OF THESE CONDITIONS, PLEASE CHECK WHO.

	Father	Mother	Other Relatives	Brother or Sister	Sons or Daughters
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which part of body?_____					
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide or mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strokes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SISTER AND BROTHERS**

How many have you had? \_\_\_\_\_

If any are deceased, give age and cause of death:

AGE	CAUSE OF DEATH
_____	_____
_____	_____
_____	_____

Write in any conditions not listed above that run in your family: \_\_\_\_\_

**PARENTS**

	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father	_____	_____	_____
Mother	_____	_____	_____

**PERSONAL HISTORY**

Where were you born? \_\_\_\_\_

**ARE YOU NOW:**

- ( ) Married ( ) Number of marriages ( ) Never Married  
 ( ) Divorced ( ) Widowed ( ) Separated

Do you have children? Yes  No  How many? \_\_\_\_\_ What are their ages? \_\_\_\_\_

**EDUCATION: Highest grade you completed:**

- ( ) 0 - 9 ( ) 10 - 12 ( ) Tech./Bus. ( ) Partial college ( ) College Graduate ( ) Post Graduate

**ARE YOU NOW HAVING SERIOUS OR DISTURBING PROBLEMS WITH YOUR:**

- ( ) Marriage ( ) Family ( ) Drugs ( ) Job or employment ( ) Financial matters ( ) Other worries

**OCCUPATIONAL INFORMATION**

**OCCUPATION** \_\_\_\_\_

**HAVE YOU EVER WORKED IN A PLACE WHERE YOU WERE OFTEN OR DAILY AROUND:**

	Yes	No		Yes	No
Solvents or cleaning fluids .....	<input type="checkbox"/>	<input type="checkbox"/>	X-ray or radioactivity.....	<input type="checkbox"/>	<input type="checkbox"/>
Insect or plant sprays.....	<input type="checkbox"/>	<input type="checkbox"/>	Lead or metal dusts or fumes.....	<input type="checkbox"/>	<input type="checkbox"/>
Plastic or resin fumes.....	<input type="checkbox"/>	<input type="checkbox"/>	Very loud noises.....	<input type="checkbox"/>	<input type="checkbox"/>
Asbestos.....	<input type="checkbox"/>	<input type="checkbox"/>	Radar or microwave.....	<input type="checkbox"/>	<input type="checkbox"/>
Silica, sandblasting, grinding/drilling dust.....	<input type="checkbox"/>	<input type="checkbox"/>			

**HABITS**

Have you ever smoked cigarettes? Yes  No

Have you smoked cigarettes in the last ten (10) years? Yes  No

How many packs a day? \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

Are you still smoking? \_\_\_\_\_

If not, when did you quit? \_\_\_\_\_

In the past year did you drink any alcohol? Yes  No

If yes, how many alcoholic drinks did you usually have (wine, beer, whiskey, cocktails)?

Total of 6 or more ..... ( ) 1 or 2 a day..... ( )

3 to 5 a day..... ( ) Only occasionally ..... ( )

Have you ever had a drinking problem for which you received treatment or which you got over by yourself Yes  No

Do you think you drink too much alcohol? ..... Yes  No

Do you use recreational drugs? ..... Yes  No   
 If yes, what kind? \_\_\_\_\_

Do you drink coffee, tea or cola drinks? ..... Yes  No   
 If yes, how much? \_\_\_\_\_

Do you exercise regularly? ..... Yes  No

Do you follow a specific diet? ..... Yes  No   
 If yes, what kind? \_\_\_\_\_