Arizona Center for Chest Diseases

INITIAL MEDICAL HISTORY FORM

1. Patient Name ____
2. Please list all medical problems and surgeries:

____

3. Please list your medications/doses below:

____

4. Do you have an allergy or a tolerance to any medications?
   Please list the medications and reactions.

____

5. Do you useTobacco: ☐ Yes ☐ No How much?_______ How long?_________Year Quit:__________
6. Do you drink alcohol; how much? Do you use recreational drugs; how much?

____

7. Do you have any close animal contact or in house pets?
   Please describe the contact.

____

8. What is/was your predominant occupation?

____

9. Have you had recent travel in the last 6 months?

____

10. How long have you lived in Arizona, and have you had Valley Fever?

____

11. Have you ever had exposure or infection with Tuberculosis?

____

12. Have you ever had a TB skin test? If so when was the test performed and was it positive or negative?

____

13. When was your last chest x-ray?

____

14. Are you married, single, or divorced?

____

15. Do you have children? If so how many?

____

16. Do you have any risk factors or concerns regarding HIV exposure?
    (IV drug use, unprotected sex, multiple sexual partners)

____

17. Family Health History:

Mom: ________________________________ Dad: ______________________________________

Brothers: ____________________________________ Sisters: ____

18. Have your received:
    - ☐ Pneumovax (pneumonia shot) When ______ Where ____________
    - ☐ Flu shot When ______ Where ____________

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REVIEW OF SYSTEMS

Please check any problem or symptom that relates to you

Patient Name ____

Category			
General:	☐ Fever	☐ Weight Gain	☐ Fatigue
	☐ Sweats	☐ Weight Loss	☐ Night Sweats
	☐ Chills	☐ Poor Appetite	☐ Weakness
Head, Eyes, Ears, Nose, Throat:	☐ Headaches	☐ Ringing In Ears	☐ Mouth Sores
	☐ Sinusitis	☐ Nose Bleeds	☐ Difficulty Swallowing
	☐ Poor Dentition	☐ Hoarseness	☐ Changes In Hearing
	☐ Migraine	☐ Change In Vision	
	☐ Changes In Voice	☐ Sore Throat	
Allergies:	☐ Hay Fever	☐ Other Allergies	☐ Sinus Congestion
	☐ Seasonal Allergies	☐ Sensitivity To Pollens Foods Or Dander	
	☐ Runny Nose	☐ Postnasal Drip	
	☐ Water Itchy Eyes		
Respiratory System:	☐ Shortness Of Breath	☐ History Of Respiratory Infections	☐ Bronchitis
	☐ Wheezing		☐ Asthma
	☐ Cough	☐ Pleurisy	☐ Emphysema
	☐ Sputum Or Phlegm Production	☐ Coughing Up Blood	☐ Valley Fever
		☐ Tuberculosis	
Cardiovascular System:	☐ Palpitations	☐ Chest Pain	☐ High Blood Pressure
	☐ Rapid Racing Heart Beat	☐ Murmurs	
		☐ History Of Rheumatic	
Gastrointestinal System:	☐ Nausea	☐ Abdominal Pain	☐ Jaundice
	☐ Vomiting	☐ Diarrhea	☐ Vomiting Blood
	☐ Heartburn	☐ Constipation	
	☐ Blood In Stools	☐ Hepatitis	
Genitourinary system:	☐ Burning on urination	☐ Foul smelling urine	☐ Prostate problems
	☐ Difficult in urination	☐ Bloody urine	☐ Urinary incontinence
	☐ Sexual dysfunction	☐ Frequent urination	
Endocrine:	☐ Diabetes	☐ Thyroid problems	☐ High cholesterol
Skin:	☐ Bruising	☐ Rash	☐ Unusual spots
	☐ Bleeding	☐ Skin cancer	
Muscles/Bones/Joints:	☐ Muscle aches	☐ Lumps or Bumps	☐ Swelling of Hands or Feet
	☐ Joint pains	☐ Cramps	
	☐ Sprains		
Nervous system:	☐ Headaches	☐ Blackout spells	☐ Weakness
	☐ Lightheadedness	☐ Seizures	
Emotional/psychiatric:	☐ Depression	☐ Panic attacks	☐ Other mental/ behavioral disorders
	☐ Anxiety		
Sleep History:	☐ Loud snoring	☐ Recent weight gain	☐ Excessive daytime Somnolence
	☐ Unrestful sleep	☐ Thrashing bed	
	☐ Insomnia		

Environmental Exposures: ☐ Have you ever been exposed to dusts, fumes, irritants, asbestos, sand blasting, welding , mining.