**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\_\_\_\_\_\_\_\_\_