Chevy Chase Pulmonary Associates

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Comprehensive Health History Questionnaire

Name_____ Birthday_____ Today's Date_____

Please complete this confidential medical history as completely as possible.

History of Present Illness: Describe active medical problems and any recent ER visits or hospitalizations

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Past Medical History: Describe all other medical conditions, surgical history, and/or previous hospitalizations

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_____

Allergies to Medication: _____

Current Medications (Name, Strength, Frequency): Please include inhalers and nasal sprays

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Names of Your Other Physicians: _____

_____

Preferred Pharmacy:

_____

Social History & Lifestyle Factors:

Cigarettes_____ Birthplace_____

Alcohol_____ Marital Status_____

Exercise_____ Asbestos Exposure_____

Diet_____ Hobbies_____

Occupation_____ Pets_____

Family History: Describe major illnesses in blood relatives (especially cardiovascular or pulmonary conditions)

Father_____

_

Mother_____

Siblings_____

Health Care Maintenance: If you have undergone any of the following tests, please indicate where and when

Chest X-Ray or CT Scan_____

Pneumonia vaccines (Prevnar 13 or Pneumovax 23) _____

Tuberculosis (Tb) Screening _____

Colonoscopy or
Sigmoidoscopy_____

Mammogram or Pap
Smear_____

REVIEW OF SYSTEMS: Please circle Yes if you experience any of the following symptoms

Constitutional

Good general health	Yes	No
Recent weight change	Yes	No
Night sweats, fevers	Yes	No
Fatigue	Yes	No

Cardiovascular

Chest pain	Yes	No
Palpitations	Yes	No
Heart trouble	Yes	No
Swelling hands/feet	Yes	No

Musculoskeletal

Muscle pain or cramps	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No

Endocrine

Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No
Hormone problem	Yes	No

Genitourinary – MALE ONLY

Blood in urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Testicle pain	Yes	No

Ear/Nose/Mouth/Throat

Hearing loss or ringing	Yes	No
Sinus problems	Yes	No
Nose bleeds	Yes	No
Sore throat/voice change	Yes	No

Respiratory

Shortness of breath	Yes	No
Cough	Yes	No
Wheezing/asthma	Yes	No
Coughing up blood	Yes	No

Neurological

Frequent headaches	Yes	No
Paralysis or tremors	Yes	No
Convulsions/seizures	Yes	No
Numbness/tingling	Yes	No

Hematologic/lymphatic

Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No

Genitourinary – FEMALE ONLY

Blood in urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Menstrual problems	Yes	No

Eyes

Wear glasses/contacts	Yes	No
Blurred/double vision	Yes	No
Eye disease or injury	Yes	No
Glaucoma	Yes	No

Gastrointestinal

Nausea/vomiting	Yes	No
Abdominal pain	Yes	No
Rectal bleeding	Yes	No
Bowel problems	Yes	No

Integumentary (Skin/Breast)

Change in hair or nails	Yes	No
Rashes or itching	Yes	No
Breast lump	Yes	No
Breast pain or discharge	Yes	No

Allergic/Immunologic

Food allergies	Yes	No
Aspirin allergy	Yes	No
Antibiotic allergies	Yes	No

Psychiatric

Insomnia	Yes	No
Confusion/memory loss	Yes	No
Depression	Yes	No
Anxiety	Yes	No

PATIENT STATEMENT: To the best of my knowledge, the information above is accurate and complete.

Patient Signature_____ **Date**_____

PHYSICIAN STATEMENT: I have reviewed this questionnaire with the patient.

Physician Signature_____ Date_____