LUNG & CHEST
REJMON DEDAJ, MD

Patient Medical History Form

Patient Information

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Today's Visit and Current Symptoms

1. What is the main reason for your visit today?

2. Please check any current problems you are experiencing and explain in detail in the comments section below.

- ☐ Shortness of breath
- ☐ Cough
- ☐ Sputum/phlegm production
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Pleurisy (Sharp pain in chest when inhaling/exhaling)
- ☐ Chest and/or arm pain
- ☐ Chest palpitations
- ☐ Leg edema (swelling)
- ☐ Hay fever/seasonal allergies
- ☐ Daytime sleepiness
- ☐ Snoring
- ☐ Fever/chills/sweats
- ☐ Weight change
- ☐ Weakness/fatigue
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Abnormal stool
- ☐ Heartburn
- ☐ Muscle aches or weakness
- ☐ Joint pain or swelling
- ☐ Rash
- ☐ Itching
- ☐ Dry skin
- ☐ Lesions
- ☐ Headache/Head trauma
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Dizziness
- ☐ Depression
- ☐ Anxiety
- ☐ Swollen glands
- ☐ Bruising
- ☐ Blood in urine
- ☐ Increased urine frequency
- ☐ Eye discharge
- ☐ Vision change
- ☐ Hearing loss
- ☐ Ear pain or discharge
- ☐ Sinus problems/nosebleeds
- ☐ Nasal congestion
- ☐ Postnasal drip
- ☐ Sore throat
- ☐ Difficulty/pain swallowing

Comments: _____

_____

_____

_____

Immunizations/Testing History

Please select any past immunizations and/or testing that you have had and list the date taken.

- ☐ Pneumonia Vaccine Date: _____
- ☐ Flu Vaccine Date: _____
- ☐ TB Skin Test Date: _____
- ☐ Pulmonary Function Test (PFT) Date: _____
- ☐ Chest X-ray/CT Scan Date: _____

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Medications/Allergies

Please list all current prescription and non-prescription medicines, vitamins, home remedies, herbs, etc.

Medication	Dose (e.g. mg/pill)	Frequency

Known allergies or reactions to medication: _____

Please list any current allergies: _____

Exposures

Have you ever been exposed to any of the following?

☐ Asbestos	☐ Chemical/Toxin	☐ Feathers	☐ Silica
☐ Ammonia	☐ Chemical Fumes/Gases	☐ Fiberglass	☐ Soldering/Welding
☐ Agent Orange	☐ Chlorine	☐ Mold	☐ Tobacco Exposure
☐ Animals/Pets	☐ Coal Dust	☐ Oil/Kerosene Heater	☐ UV Overexposure
☐ Carpenter's Wood Dust	☐ Dust	☐ Radiation	☐ Wood Burning Stove/Fireplace

Past Surgeries/Hospitalizations

Please list all prior surgeries/hospitalizations with approximate dates.

Type of Surgery/Hospitalization	Approximate Date

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Past Medical History

Please check if you have ever been diagnosed with any of the following.

☐ Acute Respiratory Distress Syndrome	☐ Colitis	☐ Hypothyroidism	☐ Pulmonary Fibrosis
☐ Acute or Chronic Respiratory Failure	☐ Congestive Heart Failure	☐ Incontinence	☐ Pulmonary Hypertension
☐ Allergies	☐ COPD	☐ Irregular Heartbeat	☐ Raynaud's Phenomenon
☐ Alzheimer's	☐ Coronary Artery Disease	☐ Kidney Stones	☐ Renal Failure
☐ Anemia	☐ Chronic Cough	☐ Leukemia	☐ Rheumatic Fever
☐ Aneurysm	☐ Cystic Fibrosis	☐ Lung Cancer	☐ Sarcoidosis
☐ Anxiety	☐ Diabetes	☐ Lung Nodule	☐ Scleroderma
☐ Arrhythmias	☐ Emphysema	☐ Melanoma	☐ Scoliosis
☐ Arthritis	☐ Fissure	☐ Migraines	☐ Seizures
☐ Aspirations	☐ GERD/Heart Burn	☐ Neuropathy	☐ Sinus Condition
☐ Asthma	☐ Heart Disease	☐ Non-Hodgkin's Lymphoma	☐ Sleep Apnea
☐ Bronchiectasis	☐ Hepatitis	☐ Obesity	☐ Sleep Disturbance
☐ Bronchitis	☐ Hernia	☐ Parkinson's Disease	☐ Stridor
☐ Cancer	☐ HIV/AIDS	☐ Pleural Effusion	☐ Stroke, TIA, CVA
☐ Cardiac Arrest	☐ Hodgkin's Disease	☐ Pleurisy	☐ Stomach Ulcers
☐ Cardiac Arrhythmias	☐ Hyperactivity Airway	☐ Pneumonia	☐ Thyroid Disorder
☐ Cardiac Disease	☐ Hypertension	☐ Pneumothorax	☐ Tuberculosis (TB)
☐ Chest Congestion	☐ Hyperthyroidism	☐ Pulmonary Embolism	

☐ Other: _____

Family History

Please check all that apply.

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Asthma	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Pulmonary Embolism	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Other (Please explain)	☐	☐	☐	☐	☐	☐	☐

Comments: _____

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Social and Wellness History

Smoking Status (please choose one):

☐ Non-smoker

☐ Former smoker Packs per day: _____ Years: _____ Quit Date: _____

☐ Current every day smoker Packs per day: _____ Years: _____

☐ Current some day smoker Packs per day: _____ Years: _____

☐ Smoker - current status unknown

Do you use e-cigarettes or vapor? ☐ No ☐ Yes How often? _____

Do you chew tobacco? ☐ No ☐ Yes How often? _____

Do you drink alcohol? ☐ No ☐ Yes How often? _____

Do you have a history of drug use/abuse? ☐ No ☐ Yes Please explain: _____

Do you drink coffee or caffeinated beverages? ☐ No ☐ Yes How many cups per day? _____

Occupation: _____

Present job concerns for health? _____

Have you ever worked in a coal mine? ☐ No ☐ Yes

Have you ever lived or worked on a farm? ☐ No ☐ Yes

Have you lived in different geographical regions in the past year? ☐ No ☐ Yes If yes, where? _____

Do you have a basement in your home? ☐ No ☐ Yes If yes, does it ever experience water damage? ☐ No ☐ Yes

Do you ever notice any mold around the sinks, tubs, pipes, or in the closets of your home? ☐ No ☐ Yes

Do you sleep with any feathered pillows or comforters? ☐ No ☐ Yes

Do you have carpet in your home? ☐ No ☐ Yes If yes, approximately how old is it? _____

Do you have any household pets? ☐ No ☐ Yes If yes, what kind? _____

Do you exercise regularly? ☐ No ☐ Yes

What are your major hobbies and interests? _____

_____