PALOUSE PULMONOLOGY & SLEEP MEDICINE

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

MEDICAL HISTORY INFORMATION SHEET

TODAY'S DATE: _____/_____/_____

NAME: _____ AGE: _____ Birth Date: (M / D / Y) _____/_____/_____

Height ____ ft ____inches Weight _____ lbs BMI _____

REASON FOR TODAY'S EXAM: _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

	High Blood Pressure		DVT		Lung Disease		Stroke
	High Cholesterol		Pulmonary Embolus		Asthma		Diabetes
	Anxiety/Depression		Tuberculosis		Heart Trouble		Pneumonia
	Kidney Disease		Nervous Disorder		Seasonal Allergies		HIV
	Thyroid Problems		Sinus		Arthritis		Hepatitis
	Drug Abuse/Alcoholism		Sleep Apnea		Gastrointestinal		Hepatitis
	Insomnia/Hypersomnia		Bleeding Tendencies				

Cancer: If Yes, What Type _____

Other: _____

History of Serious Injuries / Illnesses? YES NO If yes, please describe below.

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has had.

	High Blood Pressure		DVT		Lung Disease		Stroke
	High Cholesterol		Pulmonary Embolus		Asthma		Diabetes
	Anxiety/Depression		Tuberculosis		Heart Trouble		Pneumonia
	Kidney Disease		Nervous Disorder		Seasonal Allergies		HIV
	Liver Disease		Seizures		Arthritis		Sinus
	Drug Abuse/Alcoholism		Thyroid Problems		Gastrointestinal		
	Insomnia/Hypersomnia		Sleep Apnea				Osteoporosis

Other: _____

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____ Children: Yes No Live Alone: Yes No

Tobacco Use: Never In the Past Presently How Much? _____ How Long? _____

Alcohol Use: Daily Occasional None Other substance use or abuse? Yes No

SYSTEM REVIEW: Please describe any active problem or symptom.

General Symptoms (i.e. fever, weight gain/loss, fatigue)

Eyes / Ears / Nose / Throat _____ Heart _____ Lung _____

Allergies / Rashes _____ Muscles/Bones/Joints _____ Psychiatric _____

Endocrine (Diabetes/Thyroid) _____ Bleeding/Lymph Nodes _____ Nerves _____

Skin and / or Breasts _____ OB/Genital/Urinary _____ Abdomen _____

ALLERGIC TO LATEX: Yes No **ALLERGIC TO MEDICATIONS: Yes No**

PLEASE LIST:_____

CURRENT MEDICATIONS: