



2 Medical Park Drive Suite 3 • West Nyack, New York 10994

### PATIENT'S PERSONAL HISTORY FORM

Please take some time to complete this questionnaire. If you cannot answer or do not understand any questions, please don't worry. The doctor will review the form with you and help answer any questions. Thank you.

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_  
 Occupation \_\_\_\_\_ Medical Doctor \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Previous Occupations \_\_\_\_\_  
 Date of Last Physical Exam \_\_\_\_\_ With Whom? \_\_\_\_\_  
 Why are you here today? \_\_\_\_\_

*Please answer each of the following questions by circling "No" or "Yes":*

#### FAMILY HISTORY

Have your parents/brothers/sisters/children ever had:

Cancer, including Leukemia	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
Heart Attack	No	Yes
High Blood Pressure	No	Yes
Stroke	No	Yes
Bleeding Disorder	No	Yes
Asthma	No	Yes
Allergies	No	Yes
Liver Disease	No	Yes
Emphysema	No	Yes
Stomach or Duodenal Ulcer	No	Yes
Glaucoma	No	Yes
Blood Clots	No	Yes

#### PERSONAL HISTORY

Do you smoke? No Yes  
 How much? \_\_\_\_\_  
 Did you ever smoke? No Yes  
 Age Started \_\_\_\_\_ Age Quit \_\_\_\_\_

Do you drink? No Yes  
 How many drinks per week? \_\_\_\_\_

Do you have difficulty sleeping? No Yes  
 Snoring? No Yes  
 Daytime Sleepiness? No Yes  
 Fatigue? No Yes  
 Falling asleep while driving? No Yes  
 Wake up short of breath/gasping? No Yes

#### IMMUNIZATIONS

Have you been immunized against:

Flu? \_\_\_\_\_ Last Shot \_\_\_\_\_  
 Pneumonia? \_\_\_\_\_ Last Shot \_\_\_\_\_  
 Tetanus? \_\_\_\_\_ Last Shot \_\_\_\_\_

Have you ever had a positive reaction to a Tuberculosis skin test? No Yes

When \_\_\_\_\_ Type of Treatment, if any \_\_\_\_\_

#### ALLERGIES

Are you allergic to any medication? No Yes If Yes, what medication and what was your reaction? \_\_\_\_\_

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**Patient Personal History Form (Cont'd)**

**MEDICATIONS**

Please list medications you are currently taking including dosage:

<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>

**OPERATIONS**

Have you ever had surgery on:

Tonsils	No	Yes	When _____	Lungs	No	Yes	When _____
Appendix	No	Yes	When _____	Breast	No	Yes	When _____
Gall Bladder	No	Yes	When _____	Heart	No	Yes	When _____
Stomach	No	Yes	When _____	Weight Loss Surgery	No	Yes	When _____
Colon	No	Yes	When _____	Other	No	Yes	When _____
Thyroid	No	Yes	When _____				

**DIAGNOSED DIFFICULTIES**

Do you now, or have you in the past, had any of the following:

Epilepsy or convulsions	No	Yes	When _____	Rheumatic Fever	No	Yes	When _____
Stroke	No	Yes	When _____	Angina	No	Yes	When _____
Glaucoma	No	Yes	When _____	High Blood Pressure	No	Yes	When _____
Ear Infections	No	Yes	When _____	Cirrhosis of Liver	No	Yes	When _____
Asthma	No	Yes	When _____	Stomach or Duodenal Ulcer	No	Yes	When _____
Hay Fever	No	Yes	When _____	Colon or Bowel Trouble	No	Yes	When _____
Chronic Bronchitis	No	Yes	When _____	Anemia	No	Yes	When _____
Emphysema	No	Yes	When _____	Poor blood clotting	No	Yes	When _____
Tuberculosis	No	Yes	When _____	Diabetes	No	Yes	When _____
Abnormal Chest X-ray	No	Yes	When _____	Thyroid Problems	No	Yes	When _____
Heart Murmur	No	Yes	When _____	Varicose Veins	No	Yes	When _____
Enlarged Heart	No	Yes	When _____	Phlebitis	No	Yes	When _____
Heart Attack	No	Yes	When _____	Any other illness	No	Yes	When _____

**SYSTEM REVIEW**

Do you have any of the following complaints:

Fever	No	Yes	Chest pain/Pressure Attacks	No	Yes
Aches/Pains	No	Yes	Frequent Cough	No	Yes
Swollen glands	No	Yes	Coughing up blood	No	Yes
Chills	No	Yes	Wheezing	No	Yes
General Weakness	No	Yes	Night Sweats	No	Yes
Ear Pain	No	Yes	Swollen ankles	No	Yes
Sinus trouble	No	Yes	Poor appetite	No	Yes
Persistent Hoarseness	No	Yes	Indigestion or heartburn	No	Yes
Severe Headaches	No	Yes	Difficulty Swallowing	No	Yes
Lumps in neck	No	Yes	Nausea or vomiting	No	Yes
Neck problems	No	Yes	Abdominal pain or cramps	No	Yes
Shortness of Breath	No	Yes	Change in bowel habits	No	Yes
Poor exercise tolerance	No	Yes	Breast lump	No	Yes
Fluttering of Heart	No	Yes	Discharge from nipple	No	Yes
Unusual Heartbeat	No	Yes			

Discussed with Patient to follow-up non-pulmonary issues with PCP or appropriate specialist.