Capital Allergy and Respiratory Disease Center
Patient Medical History Form

Patient Name: _____ Date: _____
Date of Birth: _____ Occupation: _____

Past Medical History: Do you have or have you had any of the following: (please circle answers)

Diabetes	Yes	No	High or Low Blood Pressure	Yes	No
Cancer	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Arthritis/Gout/Rheumatism	Yes	No
Convulsions	Yes	No	Blood Disease	Yes	No
Hay Fever or Asthma	Yes	No	Venereal Disease	Yes	No
Lung Disease	Yes	No			
Have you ever had a blood transfusion?	Yes	No			
Are you taking or have you ever taken steroids for any reason?	Yes	No			

Current Medications:

	Name	Dosage	Frequency	Year Started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

☐ See Attached List

Drug Allergies (please list) _____

Past Surgeries and Dates, if known:

1. _____ Year: _____ 4. _____ Year: _____

2. _____ Year: _____ 5. _____ Year: _____

3. _____ Year: _____ 6. _____ Year: _____

Have you ever been advised to have a surgical procedure that which has never been done? Yes No
If so, please state the procedure and when it was recommended? _____

Social History: (please circle the answers that are applicable)

1. Do you smoke? Yes No
If yes, how many years? _____ Number of packs per day _____
If you quit, when did you quit? _____ How many packs a day did you smoke? _____
2. Do you use recreational drugs? Yes No
3. Do you drink alcohol? Yes No
How many drinks per week? _____
4. Do you work in a noisy environment? Yes No
5. Are you frequently exposed to work place irritants (Factory, Cleaning Products etc)? Yes No
6. Have you ever been in the military? Yes No

Environmental History:

Apt/House _____ Yrs Old

Urban/Rural

Heat ☐ Central ☐ Wood ☐ Gas ☐ Heat Pump ☐ Pellet ☐ Electrical

Pets ☐ Yes ☐ No Type: _____

Smoking / ETS exposure ☐ Yes ☐ No

Reason for seeing the Doctor today:

_____

_____

How did you learn about us:

_____

_____

Family Medical History:

	Diseases Known	If deceased, cause of death
Father	_____	_____
Mother	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Grandparents		
	_____	_____
	_____	_____

Review of Systems: Please indicate if you are now experiencing any of the following. (please circle)

Recent weight change	Yes	No	Joint pain	Yes	No
Fever	Yes	No	Joint stiffness or swelling	Yes	No
Fatigue	Yes	No	Muscle pains or cramps	Yes	No
Headaches	Yes	No	Dizziness	Yes	No
Chest Pain/Angina Pectoris	Yes	No	Convulsions or Seizures	Yes	No
Heart trouble	Yes	No	Chronic or frequent coughs	Yes	No
Palpitation	Yes	No	Spitting up blood	Yes	No
Swelling of feet, ankles, hands	Yes	No	Shortness of breath	Yes	No
Slow to heal after cuts	Yes	No	Burning or painful urination	Yes	No
Bleeding or bruising tendency	Yes	No	Kidney stones	Yes	No
Anemia	Yes	No	Blood in urine	Yes	No
Diabetes	Yes	No	Incontinence	Yes	No
Excessive thirst or urination	Yes	No	Moles that are irritated or bleeding	Yes	No
Very dry, flaky skin	Yes	No	Sores that have not healed	Yes	No
Eye disease or injury	Yes	No	Rash or itching	Yes	No
Blurred or double vision	Yes	No	Change in skin color	Yes	No
Glaucoma	Yes	No	Varicose veins	Yes	No
Loss of appetite	Yes	No	Change in hair or nails	Yes	No
Frequent diarrhea, nausea or vomiting	Yes	No	Snoring	Yes	No
Abdominal pain or heartburn	Yes	No	Sleep apnea	Yes	No
Peptic Ulcer (duodenal or stomach)	Yes	No	Sinus problems	Yes	No
Memory Loss or confusion	Yes	No	Nasal Blockage	Yes	No
Nervousness	Yes	No	Hoarseness	Yes	No
Depression	Yes	No	Difficulty swallowing	Yes	No
Insomnia	Yes	No	Hearing loss or ringing in the ears	Yes	No
Thyroid Problems	Yes	No	Nose bleeds	Yes	No
			Bleeding gums or mouth sores	Yes	No

If the answer to any of these is yes, please explain:

_____

_____

_____

Patient Signature: _____ Date: _____

Reviewed by Doctor/Nurse Practitioner: _____ Date: _____