Name _____

DOB _____ DATE _____

PAST MEDICAL HISTORY: (Circle Positives)

Asthma	COPD	Pneumonia	Respiratory Failure
Chronic Heart Failure	History of COVID-19	Pulmonary Hypertension	Lung Nodule(s)
Shortness of Breath	Bronchitis	Cancer (Include Type):	
Additional:_____			

FAMILY MEDICAL HISTORY:

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

PAST SURGICAL HISTORY: (Circle Positives)

Gall Bladder Appendix C Section Hysterectomy Prostate Hernia

Cancer_____

Lung Procedures_____

SOCIAL HISTORY: (Circle Positives)

Tobacco: Yes/ No _____ packs/day _____ years stopped: _____

Amount of use: Light/ Moderate/ Heavy

Alcohol: Yes/ No How Often: _____

Recreational Drugs: Yes / No Type: _____

Specific Diet: Yes / No Type: _____

ALLERGIES: _____

_____

Pharmacy Name/Phone Number: _____

Address: _____

Do you consent for our office to retrieve your prescription history? Yes / No

Reason for today's visit: _____

_____

_____

VACCINE HISTORY:

Please write dates of your last vaccination:

Flu Vaccine: _____ Pneumonia Vaccine: _____ COVID-19 Vaccine: _____

Name _____

DOB _____ DATE: _____

MEDICATIONS:

Name of Medication	Dosage	Frequency	Reason for Use