FOX VALLEY PULMONARY MEDICINE
HISTORY AND PHYSICAL

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

Please answer all questions in each section. Place a √ next to any answer you would like to discuss with the doctor.

A) **Who is your primary doctor?** _____

B) **Reason for visit**

_____
_____
_____
_____

C) **Patient Profile** ___ Single
___ Married ___Divorced
___Seperated ___Widowed

Last School Grade completed _____
Occupation _____ Retired ____ Since_____
Hobbies/Interests_____

D) **Date of your last complete medical exam** _____

E) **Health of Family** (if deceased, note age & cause of death. Include fatal accidents and suicides)

	Good	Poor	Died
Father (natural, biological)	___	___	___
Mother (natural, biological)	___	___	___
Brothers/Sisters _____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___
Spouse _____	___	___	___
Children _____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___

F) **Immunizations** - CIRCLE those you have had and the year if the most recent, if known.
FLU _____ TETANUS _____ RUBELLA _____
PNEUMONIA _____ TB SKIN TEST _____

G) **Social History:**
Do you presently smoke? ___ Yes ___ NO
If yes, how many years have you smoked? _____
How much do you smoke per day? _____
If you are an ex-smoker, how many years did you smoke? _____
How much did you smoke per day? _____

Have you traveled out of the area in the last year? _____
Area(s) traveled _____

Do you have pets? ___ **Yes** ___ **No**
If yes, What kind of pets do you have?

_____
_____

Have you ever had birds? _____

H) **Illnesses**-If you had any of the following, check the appropriate □. If **blood relative** has had any of the following check the appropriate 0

□ 0 Alcoholism
□ 0 Anemia
□ 0 Bleed Easy
□ 0 Blood Clots
□ 0 Cancer, Tumor
□ 0 Depression
□ 0 Diabetes
□ 0 Drug abuse
□ 0 Eczema, Hives, Rash
□ 0 Epilepsy, Seizures
□ 0 Eye Protection
□ 0 Glaucoma
□ 0 Heart Disease
□ 0 High Blood Pressure
□ 0 Excessive Snoring
□ 0 Liver Disease, Hepatitis or Yellow Jaundice
□ 0 Lung Disease
□ 0 Nervous Breakdown
□ 0 Thyroid Disease
□ 0 Ulcer in stomach or duodenum

I) **Hospitalizations/Surgeries**: List what the illness was, what kind of operation and the year it occurred. **Exclude** normal pregnancies

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

J) **Medications:** List all medications, birth control pills vitamins and/or herbal/natural supplements you take with or without prescription. Include strength if known.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you allergic to any medications? ___ Yes ___No
If yes, please list the medications you are allergic to.

_____
_____
_____
_____

Do you have other allergies? ___ Yes ___ No If Yes, please indicate the type of allergies _____

_____
_____

Have you ever had skin testing? ___ Yes ___ No
What year did you have the testing preformed? _____
Do you use home oxygen? _____