Alton MultiSpecialists

SURGEONS AND SPECIALISTS
MEDICAL HISTORY FORM

NAME _____ EMPLOYER _____
ADDRESS _____ WORK/CELL PHONE _____
_____ INSURANCE _____
HOME PHONE _____ PHARMACY _____
DATE OF BIRTH _____ Age: _____ EMERGENCY CONTACT _____
SOCIAL SECURITY NO. _____ Phone (home)_____ (work) _____
EMAIL ADDRESS _____
MARITAL STATUS _____ Relationship _____
REFERRED BY _____ REASON FOR VISIT _____

ALLERGIES _____

MEDICATIONS (LIST ALL MEDICATIONS YOU TAKE:)
(Include Tylenol, Asprin, Birth Control Pills, vitamins & herbal remedies)(with dosage and frequency):

_____

_____

PAST SURGERY/HOSPITALIZATIONS AND APPROXIMATE DATES _____

_____

_____

MAJOR ILLNESS HISTORY _____

SOCIAL HISTORY: **married** **single** **divorced** **widowed** **# of children**_____

Current and/or Past Smoker __ yes __ no Current PPD? _____ How long? _____ Past PPD? _____ How long? _____
Date stopped smoking: _____

Alcohol __ yes __ no If yes, how much? _____ How long? _____ Present? Past?

Illicit Drugs (illegal) __ yes __ no If yes, what kind? _____ How long? _____ Present? Past?

Pets __ yes __ no What kind? _____ Inside or Outside? _____

Occupation/Occupational Exposures (dust, fumes, smoke, chemicals): _____

_____

_____

Have you ever applied for Black Lung Benefits? __ yes __ no

If "Yes" When? _____ Where? _____

Date of Last Pneumonia Vaccine: _____ Date of Last Influenza Vaccine: _____

Date of Last TB Test: _____ Results: _____ Date of Last CXR: _____

PATIENT AND FAMILY HISTORY: List family members who have had any of the following (incl mother, father, brother, sister, grandparents):

	self	family		self	family
Diabetes	____	____	Who? _____	Sarcoidosis	____	____	Who? _____
High Blood Pressure	____	____	Who? _____	Pulmonary Hypertension	____	____	Who? _____
Stroke	____	____	Who? _____	Bronchiestasis	____	____	Who? _____
Heart Problems	____	____	Who? _____	Alpha 1 Antitrypsin Deficiency	____	____	Who? _____
Cancer	____	____	Who? _____	Lung Mass/Nodule	____	____	Who? _____
Tuberculosis	____	____	Who? _____	Seizure	____	____	Who? _____
Depression	____	____	Who? _____	Alcoholism	____	____	Who? _____
Mental Illness	____	____	Who? _____	Kidney Disease	____	____	Who? _____
Asthma	____	____	Who? _____	Arthritis	____	____	Who? _____
COPD	____	____	Who? _____	Thyroid Problems	____	____	Who? _____
History of Pneumonia	____	____	Who? _____	Obstructive Sleep Apnea	____	____	Who? _____
Bleeding Problems	____	____	Who? _____	Ulcerative Colitis or Crohn's	____	____	Who? _____
Other	____	____	Who? _____	Anesthetic Problems	____	____	Who? _____

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

____ Abdominal Pain
____ Anemia
____ Ankle Swelling
____ Black, Tar-Like Stools
____ Blood In Stool
____ Change In Bowel Habits
____ Change In Vision
____ Chest Pains
____ Chronic Cough
____ Constipation
____ Diarrhea
____ Dizziness
____ Heartburn
____ Indigestion
____ Jaundice
____ Loss Of Consciousness
____ Migraine
____ Nervousness Or Anxiety
____ Phlebitis/Blood Clots
____ Recent Weight Change
____ Severe Headache
____ Shortness Of Breath
____ Sinus Drainage
____ Stiff Joints
____ Ulcer
____ Wheezing

UPDATED BY PATIENT	DATE:	REVIEWED DATE:
Signature:		
Signature:		
Signature:		
Signature:		