NORTH TEXAS LUNG ASSOCIATES

MEDICAL QUESTIONNAIRE
Please complete all paperwork

LAST NAME____________________FIRST NAME______________MIDDLE NAME______________
BIRTHDATE____________________AGE______________GENDER: MALE ☐ OR FEMALE ☐

PHARMACY INFORMATION

Name	
Phone	
Address	

ALLERGIES
PLEASE LIST ALL FOOD AND DRUG ALLERGIES AND THE TYPE OF REACTION

Drug	**Reaction**

MEDICATION LIST
PLEASE LIST ALL MEDICATION AND INHALERS

MEDICATION	**DOSAGE**	**FREQUENCY**	**ROUTE**

SOCIAL HISTORY

PLEASE CHECK ONE OF THE FOLLOWING BELOW AND FILL IN THE BLANK.

DO YOU USE TOBACCO PRODUCTS?

☐ 1. NO, I HAVE NEVER USED TOBACCO PRODUCTS.

☐ 2. FORMER SMOKER, I DO NOT SMOKE CIGARETTES NOW. I STARTED SMOKING AT AGE ☐. I QUIT SMOKING AT AGE ☐. IN THE PAST I SMOKED AT MOST ☐ PACKS PER DAY.

☐ 3. CURRENT EVERYDAY SMOKER. I STARTED SMOKING AT AGE ☐. ON AVERAGE I SMOKE ☐ PACKS PER DAY.

PLEASE CIRCLE YES OR NO. IF YES, PLEASE SPECIFY.

DO YOU REGULARLY DRINK ALCOHOL?	YES OR NO ☐ ☐	IF YES, WHAT AMOUNT?
DO YOU DRINK CAFFEINE?	YES OR NO ☐ ☐	IF YES, HOW MANY CUPS PER DAY?
HAVE YOU EVER USED STREET DRUGS?	YES OR NO ☐ ☐	IF YES, WHAT TYPE?
ARE YOU CURRENTLY USING STREET DRUGS?	YES OR NO ☐ ☐	IF YES, WHAT TYPE?

VACCINATION HISTORY

DATE OF LAST PNEUMONIA VACCINE?	
DATE OF LAST TETNUS BOOSTER?	
DATE OF LAST INFLUENZA VACCINE?	

HAVE YOU HAD A TUBERCULOSIS SKIN TEST? YES OR NO __________

IF YES, WAS IT POSITIVE OR NEGATIVE? __________

DID YOU HAVE A CHEST X-RAY AFTER THE TUBERCULOSIS SKIN TEST? YES OR NO

IF YES, WERE THE RESULTS NORMAL? YES OR NO

SURGERY/PROCEDURE HISTORY

PLEASE CIRCLE ALL THAT APPLY AND INDICATE YEAR IF APPLICABLE.

- ☐ APPENDIX REMOVED ________
- ☐ BACK SURGERY ________
- ☐ CARDIAC BYPASS ________
- ☐ CATARACT SURGERY ________
- ☐ COLONOSCOPY ________
- ☐ ECHOCARDIOGRAM ________
- ☐ ENDOSCOPY ________
- ☐ FOOT SURGERY ________
- ☐ GALLBLADDER REMOVED ________
- ☐ HAND SURGERY ________
- ☐ HERNIA REPAIR ________
- ☐ HIP SURGERY ________
- ☐ KNEE SURGERY ________
- ☐ LUNG SURGERY ________
- ☐ MAMMOGRAM ________
- ☐ MASECTOMY ________
- ☐ NEPHRECTOMY (KIDNEY REMOVED) ________
- ☐ OTHER: ____________ ________
- ☐ PARTIAL COLECTOMY (COLON) ________
- ☐ SHOULDER SURGERY ________
- ☐ SMALL BOWEL RESECTION ________
- ☐ SPLENECTOMY (SPLEEN) ________
- ☐ STENT PLACEMENT ________
- ☐ STRESS TEST ________
- ☐ THYROID REMOVED ________
- ☐ TONSILS REMOVED ________
- ☐ VALVE REPLACEMENT ________

HOSPITALIZATION HISTORY

PLEASE LIST ANY CONDITION REQUIRING HOSPITALIZATION

REASON FOR HOSPITALIZATION	YEAR

FAMILY HISTORY

RELATIVE	AGE	IF DECEASED, AGE AT DEATH	MEDICAL CONDITIONS/CAUSE OF DEATH
MOTHER			
FATHER			
MATERNAL GRANDMA			
MATERNAL GRANDPA			
PATERNAL GRANDMA			
PATERNAL GRANDPA			
SIBLINGS			
CHILDREN			

PULMONARY HISTORY

PLEASE CIRCLE IF YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- ☐ALPHA-1 ANTITRYPSIN DEFICIENCY
- ☐ASTHMA
- ☐BRONCHITIS
- ☐COPD
- ☐COUGH
- ☐EMPHYSEMA
- ☐INFLUENZA
- ☐LUNG CANCER
- ☐PLEURISY
- ☐PNEUMONIA
- ☐PULMONARY EMBOLISM
- ☐PULMONARY FIBROSIS
- ☐PULMONARY HYPERTENSION
- ☐PULMONARY NODULE
- ☐SHORTNESS OF BREATH
- ☐SINUSITIS
- ☐SLEEP APNEA WITH CPAP
- ☐TUBERCULOSIS
- ☐WHEEZING

☐OTHER: ______________________________

MEDICAL HISTORY

PLEASE CIRCLE IF YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- ☐AIDS
- ☐ALCOHOL ABUSE
- ☐ANEMIA
- ☐ANOREXIA
- ☐ANXIETY
- ☐ARTHRITIS
- ☐BLOOD CLOTS
- ☐BLOOD TRANSFUSION (YR:______)
- ☐BULEMIA
- ☐CANCER TYPE: ______________________
- ☐CATARACTS
- ☐CHLAMYDIA
- ☐CONGESTIVE HEART FAILURE
- ☐DEPRESSION
- ☐DIABETES
- ☐EASY BLEEDING
- ☐ECZEMA
- ☐EPILEPSY
- ☐GENITAL HERPES
- ☐GENITAL WARTS
- ☐GLAUCOMA
- ☐GONORRHEA
- ☐GOUT
- ☐HAY FEVER
- ☐HEADACHES
- ☐HEARING LOSS
- ☐HEART ATTACK
- ☐HEART MURMUR
- ☐HEMORRHOIDS
- ☐HEPATITIS A, B, C
- ☐HERNIA
- ☐HIGH BLOOD PRESSURE
- ☐HIGH CHOLESTEROL
- ☐HIV
- ☐HOT FLASHES
- ☐HPV
- ☐HYPERTHYORIDISM
- ☐HYPOTHYROIDISM
- ☐INFERTILITY
- ☐KIDNEY DISEASE
- ☐LIVER DISEASE
- ☐MOTOR VECHICLE ACCIDENT
- ☐SEIZURES
- ☐SICKLE CELL ANEMIA
- ☐SKIN DISEASE
- ☐STROKE
- ☐ULCERS

☐OTHER: ______________________________