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**

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: _____

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			

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