PATIENT NAME_____ DATE_____

**Please fill out this form completely.**
Thank you.

| REASON FOR VISIT |
|---|
| WHERE IS THE PAIN/PROBLEM? |
| HOW SEVERE IS THE PAIN/PROBLEM? |
| DOES THE PAIN/PROBLEM OCCUR AT A SPECIFIC TIME? |
| WHAT OTHER PROBLEMS HAVE YOU BEEN HAVING? |
| HOW LONG HAVE YOU HAD THIS PROBLEM? |
| WHERE WERE YOU AT THE ONSET OF THIS PROBLEM? |
| COLOR OF SPUTUM (IF ANY) |

| PAST MEDICAL HISTORY | | | | |
|---|---|---|---|---|
| **PATIENT MEDICAL HISTORY** | | | **PREVIOUS HOSPITALIZATIONS, SURGERIES OR ILLNESS** | |
| Diabetes | NO | YES | | dates |
| Hypertension | NO | YES | | dates |
| Cancer | NO | YES | | dates |
| Stroke | NO | YES | **ALLERGIES** | |
| Heart trouble | NO | YES | | |
| Arthritis / gout | NO | YES | | |
| Seizures | NO | YES | | |
| Convulsions | NO | YES | **CURRENT MEDICATIONS** | |
| Bleeding tendency | NO | YES | | |
| Acute infections | NO | YES | | |
| Venereal disease | NO | YES | | |
| Hereditary defects | NO | YES | | |

| PATIENT SOCIAL HISTORY |
|---|
| MARITAL STATUS: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow |
| USE OF ALCOHOL: [ ] Never [ ] Rarely [ ] Moderate [ ] Daily |
| USE OF TOBACCO: [ ] Never [ ] Previously, but quit year [ ] |
| USE OF DRUGS: [ ] Never Type / Frequency [ ] |
| EXCESSIVE EXPOSURE AT HOME OR WORK TO: |
| [ ] Fumes [ ] Dust [ ] Solvents [ ] Air-borne particles [ ] Noise |

PATIENT NAME_____ DATE_____

**Please fill out this form completely.**
Thank you.

| PATIENT DEMOGRAPHICAL BACKGROUND (Must select at least one Race and one Ethnicity) | |
|---|---|
| **RACE** | **ETHNICITY** |
| [ ] American Indian or Alaska Native | [ ] Hispanic or Latino |
| [ ] Asian | [ ] Not Hispanic or Latino |
| [ ] Black or African American | [ ] Refused to Report / Unreported |
| [ ] More than one race | [ ] Undefined |
| [ ] Native Hawaiian | |
| [ ] Other Pacific Islander | |
| [ ] Refused to Report / Unreported | |
| [ ] Undefined | |
| [ ] White | |

LANGUAGE(S) SPOKEN_____

| FAMILY MEDICAL HISTORY | | | |
|---|---|---|---|
| | **AGE** | **DISEASES** | **CAUSE OF DEATH** |
| **FATHER** | | | |
| **MOTHER** | | | |
| **SIBLINGS** | | | |
| | | | |
| | | | |

| PHARMACY INFORMATION | | |
|---|---|---|
| **LOCAL PHARMACY** | NAME: | PHONE: |
| | ADDRESS: | |
| **MAIL AWAY PHARMACY** | NAME: | PHONE: |
| | ADDRESS: | |

| CONTACT INFORMATION | | |
|---|---|---|
| PREFERRED METHOD OF CONTACT: [ ] Phone [ ] Postal Mail [ ] Email | | |
| **PLEASE LIST ANY CHANGES TO THE FOLLOWING:** | | |
| NAME: | | |
| ADDRESS: | | |
| HOME PHONE: | WORK PHONE: | MOBILE PHONE: |
| EMAIL: | | |