ALBANY MED FACULTY PHYSICIANS
MORE THAN 350 EXPERTS PRACTICING WHAT THEY TEACH.

Pulmonary New Patient History Form

Department of Medicine

Employer and Insurance Information	Patient Information
Employer: _____	Name: _____
Address: _____	Date of Birth: _____
City/State/Zip: _____	Sex: ☐ Male ☐ Female
Business Phone: _____	Address: _____
Insurance: _____	City/State/Zip: _____
Policy # _____	Home Phone # _____
Group # _____	Marital Status: (Please check below) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant other
Emergency Contact	**Primary Care Physician**
Name: _____	Name: _____
Phone #: _____	Address: _____
Relationship: _____	City/State/Zip: _____
Pharmacy Name: _____	Other Physicians:
Address: _____	Name: _____
City/State/Zip: _____	Phone #: _____
Phone #: _____	Name: _____
	Phone #: _____
	Name #: _____

Past Medical History		
Hospitalization Operations/Illness or Injuries	Year	Hospital and Physicians

Family History
If any family member has had any of the conditions listed below please list the approximate age of onset

Conditions	Father	Mother	Brother # of ___	Sister # of ___	Children # of ____	Other/Relation
Diabetes						
High Blood Pressure						
Heart Disease						
Stroke						
Cancer						
Gout						
Arthritis						
Asthma						
Kidney Disease						
Bowel Trouble						
Ulcers						
State of Health if Living/Age						
Cause of Death/Age						

Personal Medical History If you have had any of the following please mark the appropriate date of onset					
Medical Problem	**Date**	**Medical Problem**	**Date**	**Medical Problem**	**Date**
Alcohol/Drug Abuse		Heart Problems: attack, murmur, enlarged, etc.		Thyroid Disease	
Allergies		High Blood Pressure		Treatment (radiation)	
Anemia		High Cholesterol		Bowel Trouble	
Asthma		Kidney Disease		Ulcers	
Bleeding Disorder		Low Blood Pressure		Unconsciousness	
Blood Transfusion		Measles		Urinary Tract Infections	
Breast Lump		Mental Illness		Rheumatic Fever	
Broken Bone		Mumps		Sexually Transmitted Disease	
Cancer		Pneumonia		Liver Disease	
Cataracts		Pulmonary Disease		Eye Disease	
Diabetes		PE/DVT (blood clot)		Gout	
Exposure to TB		Physical/Sexual Abuse		Arthritis	
Gallbladder Disease		Seizures		Stroke	
German Measles (rubella)		Skin Cancer			

Have you ever experienced any of the following?

Yes	No	Problems	Yes	No	Problems
		Weight loss of more than 10 pounds in the past year (without dieting)			Frequent nausea or vomiting?
		Any growths or lumps?			Difficulty swallowing?
		Any visual disturbance?			Difficulty sleeping?
		Hearing problems?			Problems with urination?
		Any problems with your teeth?			Frequent or severe back pain?
		Do you have dentures?			Unusual shakes or tremors?
		Frequent congestion?			Depression?
		Frequent cough or wheezing?			Headaches?
		Shortness of breath?			Difficulty speaking?
		Frequent swelling of your legs or ankles?			Difficulty concentrating?
		Pain or tightness in your chest, with exertion?			Dizziness?
		Difficulty swallowing?			Loss of balance?
		Abdominal pain?			Difficulty walking?
		Constipation?			**Men Only** (Any unusual discharge from the penis)

Yes	No	Problems	Yes	No	Problems
		Blood in your stools?			**Men Only** (lump in the testicles?) Do you do a self-exam?
		Nervousness?			**WOMEN ONLY**
		Crying for no apparent reason			Are you currently going through menopause? If yes, when did it begin?
		Thoughts of suicide?			Any bleeding after menopause?
		Problems at home or work?			Hot Flashes?
		Have you ever been exposed to unusual chemicals?			Lump in your breast?
		Do you practice safe sex?			Did you mother take diethylstilbestrol (DES) during her pregnancy? (Answer only if you were born after 1945.)
		Have you recently had sexual relations?			Excessive bleeding?
		Do you use any form of birth control? If you do, what form do you use?			Irregular periods?
		Frequent urination at night?			Pap test? When?
		Diarrhea?			Have you had a mammogram? When?
		Numbness in your extremities?			Abnormal pap test? When?

Please describe any other health problem:

IMMUNIZATION HISTORY	DATES	IMMUNIZATION HISTORY	DATES
VACCINE		HEPATITIS A	
DPT		HEPATITIS B	
POLIO		FLU VACCINE	
MMR		PNEUMOCCOCAL VACINE	
TETNUS/DEPHTHERIA		OTHER (Please list vaccine)	

DRUG ALLERGY OR SENSITIVITY?: (Please state drug and type of reaction)

CURRENT MEDICATIONS	
MEDICATION	Dosage and how often taken

Social History			
What is your occupation?			
Recreational activities/hobbies:			
Living arrangements:	☐ Alone ☐ Spouse ☐ Children ☐ Significant Other		
Tobacco Use:	☐ Yes ☐ No	How many years?	Quit/When
Alcohol Use:	☐ Yes ☐ No	How many years?	Quit/When
Do you exercise?	☐ Yes ☐ No	Type of exercise?	How often?
What is your height?		What is your weight?	

Pain History	
Do you have any ongoing pain problems?	☐ Yes ☐ No
Do you have pain now?	☐ Yes ☐ No
If yes, location/intensity of pain:	
What if any medications do you take for the pain relief?	
Is your pain satisfactorily controlled now?	
What relieves or intensifies your pain?	
Effect of pain on quality of life (sleep, appetite, activity)	