Capital Allergy and Respiratory Disease Center
Patient Medical History Form

Patient Name: ____________________________ Date: ___________________
Date of Birth: _____________ Occupation: _____________________________

Past Medical History: Do you have or have you had any of the following: (please circle answers)

Diabetes	Yes	No	High or Low Blood Pressure	Yes	No
Cancer	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Arthritis/Gout/Rheumatism	Yes	No
Convulsions	Yes	No	Blood Disease	Yes	No
Hay Fever or Asthma	Yes	No	Venereal Disease	Yes	No
Lung Disease	Yes	No			
Have you ever had a blood transfusion?	Yes	No			
Are you taking or have you ever taken steroids for any reason?	Yes	No			

Current Medications:

	Name	Dosage	Frequency	Year Started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

☐ See Attached List

Drug Allergies (please list) ____

Past Surgeries and Dates, if known:

1. ____________________ Year: __________ 4. ____________________ Year: __________

2. ____________________ Year: __________ 5. ____________________ Year: __________

3. ____________________ Year: __________ 6. ____________________ Year: __________

Have you ever been advised to have a surgical procedure that which has never been done? Yes No
If so, please state the procedure and when it was recommended? _________________________

Social History: (please circle the answers that are applicable)

1. Do you smoke? Yes No
If yes, how many years? _____ Number of packs per day _____
If you quit, when did you quit? _____ How many packs a day did you smoke? _____
2. Do you use recreational drugs? Yes No
3. Do you drink alcohol? Yes No
How many drinks per week? ______
4. Do you work in a noisy environment? Yes No
5. Are you frequently exposed to work place irritants (Factory, Cleaning Products etc)? Yes No
6. Have you ever been in the military? Yes No

Environmental History:

Apt/House _____ Yrs Old

Urban/Rural

Heat ☐ Central ☐ Wood ☐ Gas ☐ Heat Pump ☐ Pellet ☐ Electrical

Pets ☐ Yes ☐ No Type: ___________________________

Smoking / ETS exposure ☐ Yes ☐ No

Reason for seeing the Doctor today:

____

____

How did you learn about us:

____

____

Family Medical History:

	Diseases Known	If deceased, cause of death
Father		
Mother		
Sibling		
Sibling		
Grandparents		

Review of Systems: Please indicate if you are now experiencing any of the following. (please circle)

Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No
Chest Pain/Angina Pectoris	Yes	No
Heart trouble	Yes	No
Palpitation	Yes	No
Swelling of feet, ankles, hands	Yes	No
Slow to heal after cuts	Yes	No
Bleeding or bruising tendency	Yes	No
Anemia	Yes	No
Diabetes	Yes	No
Excessive thirst or urination	Yes	No
Very dry, flaky skin	Yes	No
Eye disease or injury	Yes	No
Blurred or double vision	Yes	No
Glaucoma	Yes	No
Loss of appetite	Yes	No
Frequent diarrhea, nausea or vomiting	Yes	No
Abdominal pain or heartburn	Yes	No
Peptic Ulcer (duodenal or stomach)	Yes	No
Memory Loss or confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No
Thyroid Problems	Yes	No
Joint pain	Yes	No
Joint stiffness or swelling	Yes	No
Muscle pains or cramps	Yes	No
Dizziness	Yes	No
Convulsions or Seizures	Yes	No
Chronic or frequent coughs	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Burning or painful urination	Yes	No
Kidney stones	Yes	No
Blood in urine	Yes	No
Incontinence	Yes	No
Moles that are irritated or bleeding	Yes	No
Sores that have not healed	Yes	No
Rash or itching	Yes	No
Change in skin color	Yes	No
Varicose veins	Yes	No
Change in hair or nails	Yes	No
Snoring	Yes	No
Sleep apnea	Yes	No
Sinus problems	Yes	No
Nasal Blockage	Yes	No
Hoarseness	Yes	No
Difficulty swallowing	Yes	No
Hearing loss or ringing in the ears	Yes	No
Nose bleeds	Yes	No
Bleeding gums or mouth sores	Yes	No

If the answer to any of these is yes, please explain:

____

____

____

Patient Signature: ____ Date: _____________

Reviewed by Doctor/Nurse Practitioner: ____________________________ Date: _____________