



**Help us take care of you. Please answer all questions.**

Name:.....Date of birth..... Age..... Sex..... Married.....  
 First MI Last Widow(er)  
 Single

Allergies: Reaction  
 Penicillin.....  
 Sulfas.....  
 Cipro.....  
 Tetracycline.....  
 To other Medications please list.....  
 Other Allergies To: Food.....  
 Environmental.....Grass.....Pollens.....

**Please list all your current medications,  
doses and how you are taking them:**

.....  
 .....  
 .....  
 .....

**Family History (Check what applies)**

Age Cause of Death COPD Seizures TB Asthma  
 Father.....  
 Mother.....  
 Brothers.....  
 Sisters.....

**Surgeries (please note the approximate year)**

Appendix.....Gallbladder.....  
 Heart.....Bypass.....  
 Colon.....Lung.....Throat.....  
 Back.....Breast.....Hernia.....  
 Tonsils.....Other.....

**Social History**

Do you smoke? No....Yes..... Up to how many packs per day?.....At what age did you start?.....  
 Did you smoke? No.....Yes.....At what age did you quit?.... Up to how many packs per day?.....Starting Age.....  
 Did you get exposed to smoke? No..... Yes..... Spouse.....Occupation.....For how many years?.....  
 Do you drink alcohol? No....Yes..... How many drinks ( beers) per week?..... For how many years?.....  
 Did you ever drink alcohol? No....Yes.....How many drinks (beers) per week?..... For how many years?.....  
 Occupation:What kind of work do (DID) you do?.....  
 Where you ever exposed to asbestos?..... What kind of work.....For how many years?.....  
 Did you ever work in a mine or were exposed to coal dust?  
 Do you live alone?.....At? Home.....Nursing Home.....ACLF.....

**Past Medical History. Do you have? (or did you ever have ?) if you have, please give date of diagnosis:**

Asthma	High Cholesterol	Prostrate Problems	Difficulty Sleeping
Bronchitis	Cancer: if so, where/what	Kidney Problems	Sleep Apnea
Emphysema	Kind?	OsteoArthritis	Periodic Limb Mvts. Sleep
Tuberculosis	Hiatal Hernia	Rheumatoid Arthritis	Insomnia
Exposure to TB	GastroEsophageal Reflux	Lupus	Narcolepsy
Pneumonia	Diverticular Disease	Diabetes	Cataplexy
Hay Fever	Gallbladder Problems	Osteoporosis	REM Behavior Disorder
Sinusitis	Stomach Ulcer	Skin Problems	Bruxism
Black Lung Disease	Bleeding Problems	Eczema	Excessive Daytime Sleepiness
Pulmonary Fibrosis	Blood Clots in Legs	Psoriasis	Sleep Walking
Coronary Artery Disease	Blood Clots in Lungs	Headaches	Sleep Talking
Angina	Easy Bruising	Heartburn	Other Sleep Disorder
Irregular Heart Rhythm	Gum Bleeding	Stroke	
Pacemaker	Swollen Glands	Hypertension	
Heart Attack			

**Height: Weight: B/P: Resp: HR: Temp:**