**MEDICAL HISTORY FORM**

**Pulmonary**

**Health**

**Consultants**

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|  |
| --- |
| TODAY’S DATE: |
| NAME: |
| DATE OF BIRTH: AGE: |

|  |
| --- |
| PHARMACY |
| Address: Telephone #: |

|  |
| --- |
| **HISTORY OF PRESENT ILLNESS**  **Reason for visit today (Chief Complaint):**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   * When did your symptom(s) first start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * What makes your symptom(s) better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * What makes your symptom(s) worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PERSONAL MEDICAL HISTORY**  Height: Ft In. Weight: Supplemental O2 |

**MEDICATIONS**

***Please list all current medications and dosages or provide a list***

|  |  |  |
| --- | --- | --- |
| Medications | Strength( mg, units) | Directions |
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Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES** **YES NO** ***Please list any allergies to medications and specify reaction***

|  |  |
| --- | --- |
| **Medication:** | **Reaction:** |
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|  |  |
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**PAST/CURRENT MEDICAL HISTORY *please circle all that apply***

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| **NEUROLOGICAL**   |  | | --- | | CVA | | Aneurysm/Bleed | | Seizure/Epilepsy | | Alzheimer’s | | Other | | **ENT**   |  | | --- | | Sinusitis | | Allergic Rhinitis | | Nasal Septum Deviation | | Other | | **ENDOCRINE**   |  | | --- | | Hepatitis | | Diabetes Mellitus | | |TSH | | |TSH | | Other | | **RHEUMATOLOGIC**   |  | | --- | | Osteoarthritis | | Rheumatoid  Arthritis | | Lupus | | Fibromyalgia | | Other | | **GENITO-URINARY**   |  | | --- | | BPH | | Bladder infection | | Kidney Stones | | Other | |
| **PULMONARY**   |  | | --- | | Chronic cough | | Pneumonia | | Asthma | | COPD/Emphysema | | Pulmonary Embolism | | DVT | | Tuberculosis | | +PPD | | Pulmonary Hypertension | | Pleurisy/Pleural effusion | | Bronchiectasis | | Lung Nodule/Mass | | Pulmonary fibrosis | | Other | |  | | **CARDIOVASCULAR**   |  | | --- | | Coronary Artery Disease | | Myocardial Ischemia/Infarct | | Angina | | Congestive Heart Failure | | Cardiac stent | | Atrial Fibrillations | | Hypertension | | Peripheral Vascular Disease | | Murmur | | High cholesterol | |  | | **GASTROITESTINAL**   |  | | --- | | Peptic Ulcer  Disease | | GERD | | Hiatal Hernia | | Hepatitis | | Colitis | | IBS | | Colon Cancer | | Gallstones | | Pancreatitis | | Other | | **HEME/ONC**   |  | | --- | | Cancer | | Anemia | | Sickle Cell | | Factor S | |  | |  | |  | |  | | Other |   **INFECTIOUS**  **DISEASE**   |  | | --- | | Pertussis | | Scarlet Fever | | Rheumatic Fever | | HIV | | Lyme’s Disease | | Other | | **PSYCHIATRIC**   |  | | --- | | Depression | | Schizophrenia | | ETOH | | Drug | | Other |   **SLEEP**   |  | | --- | | Obstructive Sleep Apnea | | Restless Leg Syndrome | |  | | Insomnia | | Narcolepsy | | Other | |

Please list all other past or present medical conditions you have been diagnosed with that are not listed above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY: (Type of Procedure/Hospital/Date) \_\_\_\_\_NO, previous surgeries**

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| --- | --- |
| **1.** | **4.** |
| **2.** | **5.** |
| **3.** | **6.** |

PULMONARY HEALTH CONSULTANTS

Medical History form 2

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HOSPITALIZATIONS \_\_\_\_\_NO, previous hospitalizations**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital and City** | **Reason** | **Physician** | **Year** |
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| **SOCIAL HISTORY**  Are you working now? YESWhat is your occupation**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  NO What was your occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Retired  Unemployed  Have you been exposed to asbestos, dust or strong fumes or Tuberculosis (TB) at your work? YES NO  If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_  Do you keep animals at home? YES NO  If yes, how many/ what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you ever smoked cigarettes? YES NO  If yes: Do you smoke now? YES NO   * At what age did you start smoking? \_\_\_\_\_ * At what age did you stop smoking?\_\_\_\_\_\_ * How many packs a day do/did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Do you use any other type of tobacco products other than smoking YES NO  If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you drink caffeine? YES NO  If yes, How often, How much and What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **SOCIAL HISTORY**  Do you consume alcoholic beverages? YES NO  If yes, how often \_\_\_\_\_\_times per \_\_\_\_\_\_\_\_ week \_\_\_\_\_\_\_\_\_ month \_\_\_\_\_\_\_\_ year  If yes, how many drinks do you have on a typical day when you are drinking?  Do you consider yourself an alcoholic?  Do you use recreational/illicit drugs? No, never Yes, in the past Yes, currently  If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

PULMONARY HEALTH CONSULTANTS

Medical History form 3

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FAMILY MEDICAL HISTORY**  \_\_\_\_No known Family history of Medical illness/disease  Please specify which relative AND for distant relatives please specify if they are on (P) PATERNAL or (M) MATERNAL side   |  |  |  |  | | --- | --- | --- | --- | | Disease | Relative | Other diseases (list) | Relative | | Asthma |  | Diabetes |  | | Emphysema or COPD |  | Other |  | | Lung Cancer |  | Other |  | | Heart Disease |  | Cancer: |  | | Blood Clotting disorder |  |  |  | | High blood pressure |  |  |  | | High cholesterol |  |  |  | |

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| **PREVENTIVE CARE**  Have you had a Flu shot since the most recent Sept. 1st? YES NO Date \_\_\_\_\_/\_\_\_/\_\_\_\_\_ Location  Have you had a Pneumonia shot in the past 10 years? YES NO Date \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Location  Have you received a TB Skin Test? YES NO Date received \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_  Results? POS NEG  If TB test was positive was a Chest X-ray done? YES NO Results: Abnormal Normal    Have you received treatment for TB? YES NO |

PULMONARY HEALTH CONSULTANTS

Medical History from 4

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS (*please check all that apply***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **GENERAL**   |  | | --- | | Weight loss/gain  #lbs. \_\_\_\_\_\_  over period of time:  \_\_\_\_\_\_\_\_ | | Fever | | Sweats/chills | | Fatigue | | Irritability | | Weakness | |  |   **EYE**   |  | | --- | | Redness | | Excessive tearing | | Visual changes | | Sensitivity to light | | Discharge | |  |   **ENT**   |  | | --- | | Sore throat | | Hoarseness | | Throat clearing | | Dental problems | | Dry mouth | | Sinus pain/congestion: chronic/ intermittent/seasonal | | Nose bleeds | | Runny nose | | Post nasal drip | | Pain | | Perforated eardrum | | Change in hearing | | Ringing in ears | | Vertigo | |  |   **HEME/ONC**   |  | | --- | | Easy bruising | |  | | **PULMONARY**   |  | | --- | | Cough | | Sputum/ phlegm | | Shortness of breath at rest | | Shortness of breath with activity | | Cough up blood | | Wheeze | | Chest pain with breathing | |  |   **CARDIOVASCULAR**   |  | | --- | | Chest pain | | Palpitations | | Extremity Swelling | | Leg pain with walking | | Heart Murmur | |  |   **GASTROINTESTINAL**   |  | | --- | | Cough after eating or drinking | | Difficulty swallowing | | Heartburn | | Nausea/Vomiting | | Loss of Appetite | | Pain or difficulty with swallowing | | Bloody/Black stools | | Jaundice | | Heartburn | | Change in bowel movements | |  | | **NEUROLOGIC**   |  | | --- | | Headaches | | Fainting spells/  Dizziness | | Tremor | | Muscle weakness | | Numbness | | Forgetfulness | |  |   **MUSCULOSKELETAL**   |  | | --- | | Limited movement of joints | | Swelling of joints | | Painful joints | | Back or neck pain | |  |   **GENITOURINARY**   |  | | --- | | Frequent Urination | | Difficulty urinating | | Painful urination | | Frequent nighttime urination | | Blood in Urine | | Frequent Urinary infections | | Erectile dysfunction | | Kidney stones | | WOMEN: Date of LMP: | |  |   **SKIN**   |  | | --- | | New skin lesion | | Rash | | Skin Cancer | | Hives | | Itching | | Color changes | |  | | **PSYCHIATRIC**   |  | | --- | | Anxiety | | Depression | | Hallucinations | |  |   **SLEEP**   |  | | --- | | Snoring | | Stop breathing with sleep | | Choking/gasping with sleep | | Tired upon awakening | | Daytime sleepiness | | Awakenings | | Awaken with headache | | Difficulty falling asleep | | Muscle weakness with emotion/laugh | | Feeling paralyzed upon awakening | | Seeing/  hearing things upon sleep entry | | Restless legs sitting/lying down | | Frequent limb movements during sleep | | Sleep walking/  Talking | | Injury to self/others with sleep | | Grinding teeth during sleep | |  | |

**To the best of my knowledge, this information is accurate and complete as of this of this date. If there are any changes, they will be added as an addendum to this document.**

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Representative Relationship to Patient Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Witness Date**

PULMONARY HEALTH CONSULTANTS

Medical History form 5

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Mailing: 542 Berlin Cross Keys Road, Suite 3-247

Sicklerville, NJ 080

**Pulmonary**

**Health**

**Consultants**

**Manuel S. Cunanan, MD**



Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

*Please use the following scale*:

*0 Would never doze*

*1 Slight chance of dozing*

*2 Moderate chance of dozing*

*3 High chance of dozing*

|  |  |
| --- | --- |
| **Situation** | **Chance of Dozing or Sleeping** |
| Sitting and reading |  |
| Watching television |  |
| Sitting inactive in a public place |  |
| While a passenger in a car without a break (an hour or more) |  |
| Laying down to rest in the afternoon when circumstances permit |  |
| Sitting and talking to someone |  |
| Sitting quietly after lunch without alcohol |  |
| In a car, while stopped in traffic for a few minutes |  |

Medical History form 6