FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Pulmonology Health History Questionnaire

Name _____ **Date of Birth** _____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe): _____

How long have you had this problem?

☐ Week(s) ☐ Month(s) ☐ Year(s)

Local Pharmacy: _____ **Phone**: ( ) _____ - _____

Location: _____ **City** _____ **State:** _____

Current Health Concerns		
Please check problems or conditions that you have experiences over the past two (2) weeks		
☐ Fever/chills or sweats	☐ Coughing up blood	☐ Heartburn
☐ Weight loss or gain	☐ Shortness of breath	☐ Ulcers
☐ Fatigue/tiredness	☐ Wheezing	☐ Vomiting or nausea
☐ Headaches	☐ Chest tightness	☐ Dark or bloody stools
☐ Allergies/hay fever	☐ Pain with breathing	☐ Frequent urination
☐ Eye/vison problems	☐ Snoring	☐ Burning urination
☐ Ear/hearing problems	☐ Calf or leg pain	☐ Easy bruising
☐ Nose/nasal problems	☐ Chest pain/angina	☐ Aching muscles
☐ Post nasal drip	☐ Dizzy spells	☐ Anxious feelings
☐ Swollen glands	☐ Stomach trouble	☐ Frequent thirst/hunger
☐ Coughing spells	☐ Indigestion	☐ Blood in urine
☐ Coughing up phlegm	☐ Constipation/diarrhea	☐ Other
Personal Health History		
Please check if you have had any of the following		
☐ Anemia	☐ Hay fever	☐ Phlebitis/blood clots
☐ Arthritis	☐ Heart attack/angina	☐ Prostate problems
☐ Asthma	☐ Heart disease	☐ Rashes
☐ Bone fractures	☐ Heart murmur	☐ Rheumatic fever
☐ Bronchitis	☐ Heart valve disease	☐ Seizures
☐ Cancer	☐ High blood pressure	☐ Sinusitis
☐ Depression	☐ Irregular heartbeat	☐ Sleep problems
☐ Diabetes	☐ Kidney stones	☐ Stroke/TIA
☐ Emphysema	☐ Nervousness	☐ Thyroid problems
☐ Gastric reflux	☐ Osteoporosis	☐ Ulcers
☐ Gout	☐ Pneumonia	☐ Urine infections

Allergies

Please list any allergies to medications or foods

Name	Symptom/Reaction

Health Maintenance

Please check whether you have had the following preventative services and enter the month and year of the service

Immunizations	Last Occurrence Month	Last Occurrence Year		Tests	Last Occurrence Month	Last Occurrence Year
Influenza vaccine				TB Skin Test		
Pneumonia vaccine						

Family History

Relative	Age	Alive (Y/N)	Medical Problems	Cause of Death
Father				
Mother				
Sibling				
Sibling				
Sibling				
Child				
Child				
Child				

Social History

Place of Birth? _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Pets at home? ☐ No ☐ Yes (please list): _____

Alcohol use: Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

If yes, how many drinks? _____ Per day _____ Per week _____ Per month

Tobacco use: Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

Age Started: _____ Age Quit: _____ Packs per day: _____

Any use of weight loss medications? (please list): _____

Occupation: _____

Have you ever been exposed to any of the following: ☐ Asbestos ☐ Dust ☐ Metal ☐ Mining ☐ Wheat Dust ☐ Chemicals

Have you ever had a positive TB skin test: ☐ Yes ☐ No

Have you ever been exposed to TB (Tuberculosis)? ☐ Yes ☐ No

Where have you lived? _____

Have you traveled abroad? If so, where? _____

Medications		
Please list any medications that you take including over the counter medications, herbs, and supplements.		
Name	**Dose**	**Frequency**

Surgical History		
Month	Year	Procedure

Recently Hospitalizations		
Date	Hospital	Reason for admission

Medical Problems

Patient/Guardian Signature: _____ Date: _____

Rev. 09/2024

Scanning Category: HHQ /Pulmonology HHQ