

NAME _____

Have you had chest surgery? YES NO

Why? _____

When? _____ Where _____

NAME _____

Have you had a bronchoscopy? YES NO

Why? _____

When? _____ Where _____

Have you had a sleep study? YES NO

What was the name and address of the sleep center:

When was the study? _____

If you have had more than one sleep study list the names and addresses and the location(s) of the other studies

When was the study? _____

Have you had a pneumonia shot? YES NO

When? _____

Have you had a skin test for tuberculosis? YES NO

When? _____

Results Don't remember Positive Negative

NAME _____

Social History

Have you ever smoked cigarettes? YES NO

Do you currently smoke cigarettes? YES NO

How many years have you smoked cigarettes? _____

How many packs of cigarettes per day have you smoked? _____

If you have quit and no longer smoke, when did you quit? _____

If you are a current smoker, have you ever quit before? YES NO
How many times? _____

Have you ever smoked cigars? YES NO

How many and how long? _____

Have you ever consumed alcoholic beverages? YES NO

If yes, how much do or did you drink? _____

Do you still consume alcohol? YES NO

If you used to consume alcoholic beverages, how much did you drink and when did you quit?

Amount _____ Quit Date _____

Did you ever use illicit or recreational drugs

such as marijuana, speed, downers, LSD, heroin? YES NO

Do you still use these drugs? YES NO

NAME _____

If yes, how much and how often? _____

If no, when did you quit? _____

NAME _____

Do you exercise? YES NO

If yes, how long and how often? _____

How many caffeinated beverages do you drink per day?

Tea _____ Caffeinated coffee _____ Soft Drinks _____

What are some of your stresses in your life at this time?

Environmental History

What states and countries where you have lived and when you lived in those residences.

List all the jobs you have worked and with any workplace exposures.

JOB	When	Hazardous exposure
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NAME _____

What pets do you have at home?

Family History (Very important to list their health conditions)

Is your mother? LIVING DECEASED

Age _____ Health Conditions _____

Is your father? LIVING DECEASED

Age _____ Health Conditions _____

Do you have any brothers or sisters? YES NO
If yes, see below.

List (Name)	Age	Living or deceased	Health Conditions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have children? (Names and ages) Health Conditions
