Cisca Pulmonary and Critical Care

Alexis A. Vazquez, D.O.

MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: _____

Please mark an "X" under the YES or NO column and provide a detailed explanation.

	YES	NO	Comments:
Do you use oxygen?			
Do you use a CPAP or BIPAP machine?			

Do you currently smoke?			Do you drink?		
How often?			How often?		
Have you ever smoked?			Do you currently use drugs?		
Start/Quit dates:			Do you have a history of drug use?		
Exposure to second hand smoke?			If YES, name of drug(s):		
Exposure to airborne irritants?			Start/Quit dates:		

PULMONARY CONDITIONS you have been diagnosed with OR are currently experiencing:

	YES	NO	Comments:		YES	NO	Comments:
Shortness of breath				Lung Cancer			
Wheezing				Bronchitis			
Asthma				Pneumonia			
Chest tightness				Recurrent cough			
Emphysema/COPD				Productive cough			
Pulmonary Embolism				Bloody cough			

OTHER MEDICAL CONDITIONS you have been diagnosed with OR are currently experiencing:

_____

_____

FAMILY MEDICAL CONDITIONS: _____

_____

_____

List any SURGERIES or HOSPITALIZATIONS:

Date:	Surgical Procedure and/or Reason for Hospitalization:	Name of Facility:

Please use the back of this form if you need additional space.