BAPTIST Pulmonary Specialists

Past Patient, Family & Social History/ System Review Form

Date: _____ _____Patient Name:_____ _____Date of Birth:_____ _____Age:_____
Allergies: None □ List Allergies:_____ ___Exercise:_____ Daily Activities:_____
Married □ Single □ Divorced □ Widowed □ Living Arrangement:_____ _____Most Recent Occupation:_____
Number Children: ____ Number Pregnancies: ____Smoking: Yes □ No □ How much? _____/day How long?____ yrs Date Quit_____
Alcohol: How much per day? _____ Caffeine (coffee, tea, cola) How much? _____
Illicit Drug Use: None □ Currently Using: _____ Prior Problem? Yes □ No □ Explain: _____

Please List All Past Surgeries with Dates	Please List all Personal Illness/Injuries and Dates

Family History: (Check only those boxes that are positive) □ Diabetes □ Heart Disease □ High Blood Pressure □ Stroke □ TB
□ Cancer □ Kidney Disease □ Anemia □ Arthritis □ Mental Illness

Please explain boxes that are checked: _____
Mother: Living □ Deceased □ Age _____ Cause of Death: _____
Father: Living □ Deceased □ Age _____ Cause of Death: _____

Review of Systems – PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL	Yes	No
Weight Loss	□	□
Fatigue	□	□
Fever	□	□
EYES		
Glasses/Contacts	□	□
Pain	□	□
Double Vision	□	□
Glaucoma	□	□
Cataracts	□	□
EAR, NOSE, THROAT		
Difficulty Hearing	□	□
Ringing in Ears	□	□
Vertigo	□	□
Sinus Trouble	□	□
Nasal Stuffiness	□	□
Frequent Sore Throat	□	□
Hoarseness	□	□
CARDIOVASCULAR		
Murmur	□	□
Chest Pain	□	□
Palpitations	□	□
Dizziness	□	□
Fainting Spells	□	□
Short of Breath	□	□
Difficulty Lying Flat	□	□
Swelling Ankles/Other	□	□

RESPIRATORY	Yes	No
Cough	□	□
Coughing Blood	□	□
Wheezing	□	□
Chills	□	□
GASTROINTESTINAL		
Heartburn	□	□
Nausea/Vomiting	□	□
Constipation	□	□
Change in BM's	□	□
Diarrhea	□	□
Difficult Swallowing	□	□
Jaundice	□	□
Abdomen Pain	□	□
Black BM	□	□
GENITOURINARY		
Pain Urinating	□	□
Burning	□	□
Frequency	□	□
Nighttime	□	□
Blood in Urine	□	□
Difficulty Urinating	□	□
History Kidney Stones	□	□
History Sexually	□	□
Transmitted Disease	□	□
Abnormal Discharge	□	□
FEMALES ONLY:		
Age Onset of Periods	□	□
Age Onset of Menopause	□	□
Are Period Regular?	□	□

HEMATOLOGIC/LYMPH	Yes	No
Easy Bruising	□	□
Gums Bleeding Easily	□	□
Enlarged Glands	□	□
Prolonged Bleeding	□	□
MUSCULOSKELETAL		
Join Pain/Swelling	□	□
Stiffness	□	□
Muscle Pain	□	□
Back Pain	□	□
SKIN		
Rash/Sores	□	□
Lesions	□	□
Itching/Burning	□	□
NEUROLOGICAL		
Seizures	□	□
Weakness/Paralysis	□	□
Numbness	□	□
Tremors	□	□
Memory Loss	□	□
ENDOCRINE		
Loss of Hair	□	□
Heat/Cold Intolerance	□	□
Change in Nails	□	□
ALLERGIC/IMMUNOLOGIC		
Hay Fever/Asthma	□	□
Hives/Eczema	□	□
PSYCHIATRIC		
Anxiety/Depression	□	□
Mood Swings/Difficult Sleep	□	□

Signature Staff Member Review of Completion _____ Signature of Physician Review _____