BAPTIST Pulmonary Specialists

Patient Medical History

Name:_____ Who is your PCP/ referring physician? _____

List all medications; including aspirin, herbal medicines, vitamins, and diet pills you take on a regular basis (list medication name, strength, and dosage):

Medication	Taken For	Dose	Frequency

Note: Please provide additional medication list if necessary

List all medications or substances you are allergic to:

□ Codeine □ Erythromycin □ Penicillin □ Sulfa □ Tetracycline □ Ct/IVP Contrast Dye

□ Latex □ Other _____

Past Medical History:

Allergic Rhinitis	□ Yes	□ No	Hepatitis	□ Yes	□ No
Allergy Shots	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Anemia	□ Yes	□ No	HIV/AIDS	□ Yes	□ No
Anxiety/Depression	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Arthritis	□ Yes	□ No	Leukemia/Lymphoma	□ Yes	□ No
Asthma	□ Yes	□ No	Lung Disease	□ Yes	□ No
Autoimmune Disease	□ Yes	□ No	Migraine Headaches	□ Yes	□ No
Bleeding Disorder	□ Yes	□ No	Neurologic Disorders	□ Yes	□ No
Cancer	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Congestive Heart Failure	□ Yes	□ No	Pulmonary Embolism or DVT	□ Yes	□ No
Diabetes	□ Yes	□ No	Sleep Apnea	□ Yes	□ No
Emphysema/COPD	□ Yes	□ No	Stroke	□ Yes	□ No
Esophageal Reflux	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Heart Disease	□ Yes	□ No	Other Condition	□ Yes	□ No
Currently Seeing a Cardiologist	□ Yes	□ No			