NEWPORT PULMONARY AND ENDOCRINE ASSOCIATES

HEALTH HISTORY FORM

(Please fill out both pages of Health History Form and bring with you to our office.)

Patient's Name: _____

Date of Birth: _____
Today's Date: _____
Primary Doctor (or Referring Doctor): _____

REASON FOR REFERRAL: _____
_____

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE BEEN EXPERIENCING:

- GENERAL: weight change; change in strength; fatigue; cold intolerance; heat intolerance
- HEAD: headaches; vertigo/dizziness; head injury
- EYES: worsening vision; double vision; excessive tearing; pain around/in eyes
- EARS: change in hearing; tinnitus
- NOSE: bloody nose; runny nose; nasal congestion; post-nasal drip
- MOUTH: dental difficulties; bleeding gums; recent tooth extraction
- NECK: neck tenderness/stiffness; hoarseness; difficulty swallowing; choking sensation
- BREAST: lumps; breast tenderness; nipple discharge
- CHEST: shortness of breath; wheezing; cough; coughing up blood
- HEART: chest pain; palpitations; fainting; lightheadedness
- ABDOMEN: change in appetite; difficulty swallowing; abdominal pain; diarrhea; constipation; vomiting; nausea; blood in stool; heartburn or reflux;
- GU: urinary urgency; pain with urination; increased frequency urination; blood in urine
- GYN: change in menses; pain with menses; vaginal discharge; pelvic pain
- MUSCLE: pain in muscles or joints; no change in motion;
- NEURO: weakness of muscles; tremors; seizures; loss of balance
- PSYCH: depression; change in sleep habits;
- SKIN: rash; flushing; pallor

PLEASE LIST ALL YOUR PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS (including supplements):

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: _____

PLEASE LIST ALL YOUR MEDICAL CONDITIONS:

_____ _____
_____ _____
_____ _____

FAMILY HISTORY:

Family Member	Current age/Age at expiration	Medical issues
Father		
Mother		
Brother(s)		
Sister(s)		

SOCIAL HISTORY:

Do you currently smoke or chew tobacco?
If yes, how many packs per day?
If no, did you previously smoke? If so, when did you quit tobacco?

Do you drink alcohol?
How many drinks per week?

Do you currently, or have you ever, used recreational drugs?
If yes, when was the last time you used them?