NEWPORT PULMONARY AND ENDOCRINE ASSOCIATES
PRINTABLE HEALTH HISTORY

Patient's Name: _____ Today's Date: _____
Social Security Number: _____ Date of Birth: _____

Past Medical History
Previous Physician's name: _____ Date of last exam:_____

Have you ever been hospitalized? ☐Yes ☐No If yes, what for? _____

Have you ever been tested for hepatitis A, B or C? ☐Yes ☐No Which hepatitis virus?_____

Have you been vaccinated for hepatitis B? ☐Yes ☐No If yes, date vaccine series completed _____

Have you been vaccinated for hepatitis A? ☐Yes ☐No If yes, date vaccine series completed _____

Last Tuberculosis (TB) Screening? _____ Result of TB screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray: _____ Result of chest x-ray: ☐Positive ☐Negative

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina ☐Shortness of breathe ☐Eye disorder / Glaucoma ☐Diabetes

☐High cholesterol ☐Asthma ☐Seizures ☐Kidney / Bladder problems

☐High blood pressure ☐Lung problems / cough ☐Stroke ☐Liver problems / Hepatitis

☐Low blood pressure ☐Sinus problems ☐Headaches / Migraines ☐Arthritis

☐Heartburn (reflux) ☐Seasonal allergies ☐Neurological problems ☐Cancer

☐Anemia or blood problems ☐Tonsillitis ☐Depression / Anxiety ☐Ulcers/colitis

☐Swollen ankles ☐Ear problems ☐Psychiatric care ☐Thyroid problems

Please describe any current or past medical treatment not listed above

_____
_____

Please list your past surgeries

_____
_____

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No
Please list:
_____

Medications
Please list:
_____

_____

PLEASE COMPLETE REVERSE SIDE

Patient initials:_____

Social and Preventive History

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐Yes ☐No

Do you use seatbelts while driving? ☐Yes ☐No Do you wear a helmet while riding a bike? ☐Yes ☐No

Family History
Living Age (or age at death) List serious illnesses

Mother ☐Yes ☐No _____ _____

Father ☐Yes ☐No _____ _____

Sisters ☐Yes ☐No _____ _____

☐Yes ☐No _____ _____

☐Yes ☐No _____ _____

Brothers ☐Yes ☐No _____ _____

☐Yes ☐No _____ _____

☐Yes ☐No _____ _____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness Which family member?
Anemia or Blood disease _____
Cancer _____
Diabetes _____
Glaucoma _____
Heart disease _____
High blood pressure _____
HIV disease / AIDS _____
Mental Illness / Depression _____
Stroke _____
Other serious illness _____

Females: Gynecological History
How many times have you been pregnant? _____ Date of last Pap Smear:
_____

Have you had an abnormal Pap Smear? ☐Yes ☐No Diagnosis: _____ Follow up: _____

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis:
_____
Date of last mammogram: _____ Mammogram results:
_____

Have you ever had a breast biopsy? ☐Yes ☐No Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date _____