SLEEP & LUNGS
Naga Chigurupati, MD

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PATIENT MEDICAL HISTORY

Patient's Name _____ **Date of Birth** _____

Occupation _____ **Do you have an Advanced Directive (Living Will)** ☐Yes ☐ No

Pharmacy name and address: _____

_____

MEDICATIONS: List all prescription and over-the-counter drugs, their strength (mg), and # of tablets/day you are currently taking.

Drug	Strength (mg, mcg)	Number Taken Per Day	Drug	Strength (mg, mcg)	Number Taken Per Day

ALLERGIES: List all known allergies, including medications, and reactions.

Allergy:	Reaction:

MEDICAL HISTORY: Indicate if you have ever had any of the following.

Yes	No		Yes	No		Yes	No	
		High blood pressure			Yellow jaundice			Hepatitis
		Diabetes			Gallstones			Glaucoma
		Peptic ulcers			Kidney stones			Lung problems/asthma
		Heart attack			Diverticulosis			Stroke
		History of heart murmur			Thyroid problem	List Accidents & Broken bones:		
		Cancer (type)			STD infections			

Females Only: Number of pregnancies: Number of live births: Number of miscarriages:
Birth control method: Have you experienced menopause? ☐ Yes ☐ No

SURGICAL HISTORY: List all operations and hospitalizations and any complications.

Year	Type of operation/hospitalization	Complications

FAMILY HISTORY: Indicate if your family has a history of these conditions by checking 'F' for father, 'M' for mother, and/or 'S' for sibling. (May check more than one)

Heart Disease	☐F ☐M ☐S	Kidney problems	☐F ☐M ☐S	Diabetes	☐F ☐M ☐S	Seizure disorder	☐F ☐M ☐S
Cancer (type)	☐F ☐M ☐S	Depression	☐F ☐M ☐S	Schizophrenia	☐F ☐M ☐S	Early senility	☐F ☐M ☐S
Alcoholism	☐F ☐M ☐S	Stroke	☐F ☐M ☐S	Obesity	☐F ☐M ☐S		
Manic-depressive disorder	☐F ☐M ☐S	High blood pressure	☐F ☐M ☐S	Other (specify):	☐F ☐M ☐S		

SOCIAL HISTORY: Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Yes ☐ No Do you smoke? If YES, how many packs per day:
If NO, have you ever smoked in the past?

☐ Yes ☐ No Do you drink alcohol? If YES, what kind and how much:
If NO, have you drunk alcohol in the past?

☐ Yes ☐ No Do you use a nebulizer or CPAP or home oxygen? Please circle all that apply

☐ Yes ☐ No Have you ever had a blood transfusion? If yes, specify when:

☐ Yes ☐ No Have you ever been on a ventilator?

☐ Yes ☐ No Do you have pets at home?

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ADDITIONAL MEDICATIONS

MEDICATION NAME	DOSE	FREQUENCY