Pulmonary Medical Associates, LLP
222 High Street, Ste 102
Newton, NJ 07860

Date:_____

Patient Name:_____ DOB:_____

HEALTH QUESTIONNAIRE

Please list all medications that you are now taking, strength and how often. Include non-prescription medications, vitamins and herbal supplements.

Are you allergic to any medications? ___YES ___NO If yes, please list them and the reaction they cause.

Are you under the care of any other doctor for any medical problems? ___ YES ___NO
If yes, please list the doctor and what you are under their care for.

Please list any surgeries/hospitalizations (including the year), start with most recent:

Procedures: (list year)

EGD	Colonoscopy	Stress Test
EKG	Spirometry/PFT	ECHO

Year of last:

Tetanus Shot:	Pneumonia Vaccine:
Flu Vaccine:	Shingles Vaccine:

Social History:

Recreational Drug Use: Current/Past/Never

Smoking: Currently/Past/Never Packs/day:_____ Type: ___Cigarettes ___ Cigars ___Vape

Alcohol: Currently/Past/Never Drinks/day:_____

Have you had any falls within the last 6 months? __ YES __ NO

OVER

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Date:_____

Patient Name:_____ DOB:_____

Diabetic Patients Only: Please indicate the Date of last exam and Doctor seen:

Retinal or Dilated Eye Exam: _____

Nephropathy Screening: _____

Women Only: Date of last:

PAP _____ (abnormal?_____) Mammogram _____ (abnormal?_____)

Bone Density _____

Men Only: Date of last:

Prostate Exam _____ Last PSA (Prostate Blood Test) _____

Personal Medical History: (Please check all that apply)

☐ADHD	☐Depression	☐Kidney Stones	☐Stroke
☐Alcoholism	☐Diabetes: 1 or 2	☐Kidney Disease	☐Thyroid Disorder
☐Allergies, Seasonal	☐Diverticulitis	☐Lupus	☐Ulcerative Colitis
☐Anemia	☐DVT (Blood Clot)	☐Liver Disease	
☐Anxiety	☐Eczema	☐Macular Degeneration	
☐Arrhythmia (irregular heart beat)	☐Emphysema	☐Migraines	
☐Arthritis	☐Gallstones	☐Nosebleeds	
☐Asthma	☐GERD (acid reflux)	☐Neuropathy	
☐Bipolar	☐Glaucoma	☐Osteopenia/Osteoporosis	
☐Bladder problems/Incontinence	☐Heart Disease	☐Parkinson's Disease	
☐Bleeding Problems	☐Heart Attack (MI)	☐Peripheral Vascular Disease	
☐Cancer:_____	☐Hiatal Hernia	☐Peptic Ulcer	
☐Carpal Tunnel	☐High Blood Pressure	☐Pulmonary Embolism (PE)	
☐Headaches	☐High Cholesterol	☐Rheumatoid Arthritis	
☐Crohn's Disease	☐HIV	☐Sciatica	
☐COPD	☐Hepatitis	☐Sleep Apnea	
☐Dementia	☐Irritable Bowel Syndrome		

Please list any other medical conditions not listed above:

_____

_____

Family History:

If any blood relative has suffered from the following conditions, please circle and indicate which relative.

Heart Disease	Stroke	Asthma	Glaucoma
Diabetes	High Blood Pressure	Emphysema/Lung Disease	Mental Health
Thyroid	High Cholesterol	Cancer	Substance Abuse

Patient Signature:_____ Date:_____