Welcome to Pulmonary Associates

To help our office serve you more efficiently, fill in this health inquiry form.
All response are confidential

Patient Name_____ Date_____

PCP/Referring Physician_____Phone_____

Chief Complaint_____

Medical History

Do you or any of your family members have any of the following:

	Patient	**Family**
High Blood Pressure	_____	_____
Asthma, Breathing Order	_____	_____
Angina, Heart Disease, Palpitations	_____	_____
Bleeding Disorder	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Sleep Apnea	_____	_____
DVT, Pulmonary Embolism	_____	_____

Please list all Medications,Vitamins, Dietary Supplements, Herbal Medicine:

_____

_____

_____

Have you had any Chest X Rays and Chest CT Scans? _____
Where? _____

Allergies to the Enviroment_____

Alleriges to Medication_____