**Longmont Pulmonary & Critical Care Associates**

Patient Legal Name: _____

**Medications:**

| **Name:** | **Dosage:** | **Home many times per day:** |
|---|---|---|
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| | | |

**(If you need additional space please add on the back of this page)**

**Allergies to medications:**

| **Name:** | **Reaction:** |
|---|---|
| | |
| | |
| | |
| | |
| | |

**FOOD ALLERGIES:**

**Personal history of past/present health conditions:**

| YES | NO | DISEASE | YES | NO | DISEASE: | YES | NO | DIESASE: |
|---|---|---|---|---|---|---|---|---|
| | | Alcoholism | | | Crohn's Disease | | | Hypertension |
| | | Allergies/ Hayfever | | | Cerebral Vascular Accident (Stroke) | | | Hyperthyroidism |
| | | Anemia | | | Depression | | | Hypothyroidism |
| | | Anxiety | | | Diabetes. Type: 1 2 | | | Joint Pain |
| | | Arthritis | | | Deep Vein Thrombosis (DVT) | | | Kidney Infections |
| | | Asthma | | | Epilepsy | | | Kidney Stones |
| | | Atrial Fibrillation | | | Emphysema/chronic bronchitis | | | Migraine |
| | | Blood Transfusions | | | Fracture | | | Multiple Sclerosis |
| | | Coronary Artery Disease | | | Gastric Ulcer | | | Obesity |
| | | Cancer. Type: | | | Gastrointestinal Disease | | | Old MI |
| | | Cardiac Pacemaker | | | GERD | | | Osteoarthritis |
| | | Cardiovascular Disease | | | Gestational Diabetes | | | Osteoporosis |
| | | Congestive Heart Failure | | | Gout | | | Pneumonia |
| | | Cirrhosis | | | Heart Murmur | | | Progressive Neurological Disease |
| | | Colitis | | | Hepatitis | | | Prostate Trouble |
| | | COPD | | | High Cholesterol | | | Pulmonary Disease |
| | | Chronic Renal Failure | | | Hyperlipidemia | | | Renal Failure |
| | | | | | | | | |

| YES | NO | DISEASE | YES | NO | DISEASE | YES | NO | DISEASE |
|---|---|---|---|---|---|---|---|---|
| | | Rheumatic Fever | | | Rheumatoid Arthritis | | | Sleep Apnea |
| | | Sexually Transmitted Disease | | | Terminal Illness | | | Thyroid Disease |
| | | TIA | | | Tuberculosis | | | |
| | | Other Medical History: | | | Hospitalizations: | | | |

**Smoking:**

Are you a current smoker: Yes No

Have you ever smoked: Yes No How many years did you smoke: _____ Average packs/day: ____

Date you quit smoking: _____

**Alcohol Intake:**

Non- Drinker Occasional Moderate Alcohol Consumption

Heavy Alcohol Consumption Recovering Alcoholic

**Surgical/Procedural History: (please list all surgeries and procedures that you have had completed. The dates are not needed):**

_____
_____
_____
_____
_____
_____
_____
_____

**Family History:**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | Alcoholism | | | Hypercholesterolemia |
| | | Anemia | | | Hyperlipidemia |
| | | Anxiety | | | Hypertension |
| | | Asthma | | | Hypothyroidism |
| | | Cancer. Types | | | Kidney Disease |
| | | Coronary Artery Disease | | | Liver Disease |
| | | Cardiovascular Disease | | | Multiple Births |
| | | Congestive Heart Failure | | | Osteoarthritis |
| | | Congenital Anomaly | | | Osteoporosis |
| | | COPD | | | Pulmonary Disease |
| | | Crohn's Disease | | | Stroke |
| | | Depression | | | Substance Abuse |
| | | Epilepsy | | | Sleep Apnea |
| | | GERD | | | Other: |