Mary Lanning HEALTHCARE

Pulmonary and Sleep Clinic
Patient Medical History Information

Date:_____

Name:_____ Date of Birth:_____
Last First Middle

Patient History

Do you use tobacco? ❑ Yes ❑ No If yes, how much?_____

Do you use alcohol? ❑ Yes ❑ No If yes, how much?_____

Do you use recreational drugs? ❑ Yes ❑ No If yes, how much?_____

Operations and outpatient procedures (including dates):_____

_____

_____

Hospitalizations other than surgery:_____

Have you ever had any problems with anesthesia? ❑ Yes ❑ No If yes, explain:_____

_____

Personal and Family History – **Mark ONLY the boxes below of which you have a personal or family history**

	Self	Father	Mother	Siblings
Alive (A) / Deceased (D)	**n/a**			
Alzheimer's				
Anxiety				
Arthritis				
Asthma				
Bladder / Prostate Problems				
Blood Disorder (Anemia, Leukemia, etc.)				
Cancer (Specify type)				
COPD				
Depression				
Diabetes (Indicate Type I or Type II in box)				
DVT (Blood clots in legs)				
Emphysema				
Epilepsy (Seizures)				
Gastrointestinal				
Heart problem (Heart Attack, Atrial Fib., etc.)				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Liver Problems / Hepatitis				
Osteoporosis				
Pacemaker				
PE (Blood clots in lungs)				
Skin Issues				
Sleep Apnea				
Stroke				
Thyroid				
Other:_____				
None of the Above				