UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
NORTHWEST RESPIRATORY ASSOCIATES

Patient Label

Health History Form

DATE: ________________

NAME: Last ____________________________ **First** ____________ **MI**_____**Gender:** ☐ **M** ☐ **F Birthdate:** __________

REASON FOR VISIT: ____

Allergies: **Medication or Substance** **Reaction**

☐ No Allergies

Medication or Substance	Reaction

Current Medicine: OR ☐ See attached list

Label – Name	Dose	Frequency

Social History

☐ Single ☐ Married (their name: _____________) ☐ Domestic Partner (their name: ______________) # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _________ Years Smoked _________ Date Quit __________
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit __________
Drinks per Day ______ Drinks per Week ______ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week ________ ☐ No ☐ Quit Date Quit __________
Have you ever used injected/IV drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone)

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female Birth Control: ____________________

Are you working? ☐ Yes What do you do? ____________________________ ☐ No ☐ Retired ☐ Disabled

Medical History

Please check box for those conditions you have now or have ever had

☐ Acute Interstitial Pneumonitis
☐ Allergic Broncholpulmonary Aspergillosis
☐ Allergic Rhinitis
☐ ARDS (Acute Respiratory Distress Syndrome
☐ Asbestos Exposure
☐ BOOP/COP
☐ Bronchiectasis
☐ Collagen Vascular Disease
☐ Coronary Artery Disease
☐ Cough
☐ Cystic Fibrosis
☐ Deep Vein Thrombosis
☐ Diaphragm Disorder
☐ Hemoptysis
☐ Hypersensitivity Pneumonitis
☐ Idiopathic Pulmonary Fibrosis
☐ Interstitial Lung Disease
☐ Latent TB Infection
☐ Lung Abscess
☐ Lung Cancer
☐ Lung Nodule
☐ Narcolepsy
☐ Neuromuscular Disease
☐ Nontuberculous Mycobacteria
☐ Occupational Lung Disease
☐ Pleural Effusion
☐ Pneumoconiosis
☐ Pneumonia
☐ Pulmonary Embolism
☐ Pulmonary Hypertension
☐ Pulmonary Vasculitis
☐ Sarcoidosis
☐ Sinus Disease
☐ Sleep Apnea - Central
☐ Sleep Apnea - Obstructive
☐ Venous Thromboembolism

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Patient Label

Medical History (continued)

☐ No Past Medical History
☐ Allergies/Hay Fever
☐ Anemia
☐ Anesthesia Problems
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding/Clotting Disorder
☐ Blood Transfusion
☐ Cancer
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Gastric Ulcer
☐ GERD
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Hepatitis: _________
☐ HIV
☐ Hypertension
☐ Insomnia
☐ Kidney Disease
☐ Lipid/Cholesterol
☐ Lung Disease
☐ Musculoskeletal
☐ Myocardial Infarction
☐ Osteoporosis
☐ PPD
☐ Seizures
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disease
☐ Tuberculosis

☐ Other (Please list): ____
____

Surgical History — Please check box for any surgery you have had, indicate the year

☐ No Past Surgical History
☐ Aortic Aneurysm Repair (__)
☐ Appendectomy (_______)
☐ Breast Surgery (_______)
☐ Bronchoscopy (_______)
☐ CABG (_____)
☐ Carotid Endarterectomy (__)
☐ Chest Tube (_______)
☐ Coronary Endarterectomy (____)
☐ Esophageal Surgery (_______)
☐ Gall Bladder Surgery (_______)
☐ Heart Surgery (_______)
☐ Hip Surgery (_______)
☐ Knee Surgery (_______)
☐ Laryngeal Surgery (______)
☐ Laryngoscopy (_______)
☐ Lung Resection (_______)
☐ Lung Surgery (_______)
☐ Lung Transplant (_______)
☐ Pleural Drainage (_______)
☐ Sinus Surgery (_______)
☐ Splenectomy (_______)
☐ Thyroidectomy (_______)
☐ Tonsillectomy (_______)
☐ Valve Replacement (______)

☐ Aortic Aneurysm (_______)
☐ Back Surgery (_______)
☐ Brain Surgery (_______)
☐ Breast Lumpectomy (_____)
☐ Cardiac Catheterization (_______)
☐ C-Section (_______)
☐ Cosmetic Surgery (_______)
☐ Eye Surgery (_______)
☐ Head Surgery (_______)
☐ Heart Surgery (_______)
☐ Hernia Repair (_______)
☐ Hip Replacement (_______)
☐ Hip Surgery (_______)
☐ Hysterectomy (_______)
☐ Knee Replacement (______)
☐ Knee Surgery (_______)
☐ Lung Surgery (_______)
☐ Pacemaker (_______)
☐ Prostate Surgery (_______)
☐ Spleen Surgery (_______)
☐ Stomach Surgery (_______)
☐ Tonsillectomy (_______)
☐ Tubal Ligation (_______)
☐ Vasectomy (_______)

☐ Other (Please list.: ____
____
____

History of Hospitalizations (include surgeries noted above)

If you required hospitalization for an illness *other than the disease you are being seen for today* please describe below

Month/Year	**Illness**	**Month/Year**	**Illness**

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Patient Label

Family History–Check all that apply

Relationship	First Name	Status (circle)	Allergies	Arthritis	Asthma	Autoimmune	Bleeding Disorder	Cancer	Clotting Disorder	COPD	Cystic Fibrosis	Depression	Diabetes	Heart Disease	Heart Failure	Hyperlipidemia	Hypertension	Immunodeficiency	Lung Cancer	Lung Disease	Narcolepsy	Neuromusculardystrophy	Sleep Apnea	Stroke	Sudden Death	Tuberculosis
Mother		alive deceased																								
Father		alive deceased																								
Sister		alive deceased																								
Brother		alive deceased																								
Maternal Grandmother		alive deceased																								
Maternal Grandfather		alive deceased																								
Paternal Grandmother		alive deceased																								
Paternal Grandfather		alive deceased																								

Review of Systems (current symptoms) – please check only if these are bothering you at this time

Gastrointestinal
- ☐ Poor Appetite
- ☐ Stomach Pain
- ☐ Diarrhea
- ☐ Nausea
- ☐ Constipation
- ☐ Abdominal Swelling
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Trouble Swallowing
- ☐ Heartburn/Indigestion
- ☐ Black Tarry Stools
- ☐ Other: _______________
- ☐ Rectal Bleeding
- ☐ Other: _______________
- ☐ Other: _______________

Constitutional
- ☐ Fevers
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Weight Loss

Head / Eyes
- ☐ Cataracts
- ☐ Poor Vision
- ☐ Dry Eyes
- ☐ Color Blindness

Ears/Nose/Mouth/Throat
- ☐ Hearing Loss
- ☐ Heavy Snoring
- ☐ Chronic Sinus Congestion
- ☐ Bad Teeth

Respiratory (lungs)
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema (COPD)

Heart
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ High Blood Pressure

Genitourinary
- ☐ Sexual Problems
- ☐ Blood in Urine
- ☐ Burning with Urination
- ☐ Leakage of Urine

Muscles/Bones
- ☐ Chronic Pain
- ☐ Muscle Weakness
- ☐ Arthritis
- ☐ Muscle Cramping
- ☐ Bone Pain
- ☐ Joint Pain

Skin
- ☐ Rash
- ☐ Itching
- ☐ Jaundice
- ☐ Psoriasis

Neurological
- ☐ Headaches
- ☐ Confusion
- ☐ Seizures (Epilepsy)
- ☐ Tremor (shaking)

Vascular
- ☐ Blood Clots
- ☐ Varicose Veins

Psychosocial
- ☐ Anxiety / Nerves
- ☐ Depression
- ☐ Abusive Relationship
- ☐ Feeling Worthless
- ☐ Sexual Problems
- ☐ Want to Hurt Yourself
- ☐ Sleep Problems
- ☐ Want to Hurt Others
- ☐ Alcohol Use
- ☐ Drug Use

Endocrine
- ☐ Hot Flashes
- ☐ High Thirst
- ☐ Bothered by Heat
- ☐ Bothered by Cold

Blood / Lymph
- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising
- ☐ Easy Bleeding