RICHARD M. SNEERINGER, M.D.
MURTHY S. VUPPALA, M.D.
ALAN McCRORY, M.D.
MISBAH F. SIDDIQUI, M.D.

PULMONARY & SLEEP ASSOCIATES OF HUNTSVILLE, P.C.

Board Certified in Critical Care, Sleep and Pulmonary Medicine

725 Madison Street
Huntsville, AL 35801
256-883-2112
FAX 885-0037

PATIENT HISTORY FORM

Welcome to Pulmonary and Sleep Associates of Huntsville. In order to ensure your best care, it is important that you take the time to complete both sides of this medical questionnaire. Thanks.

Name _____ Date of Birth _____

Referring Doctor _____ Primary Doctor _____

State in your own words the reason for today's visit:

Past Medical History:

List any known medical problems and the physician managing them:

Medical Problems	Physician	Medical Problems	Physician

List past surgeries and the year performed:

Surgery	Year	Surgery	Year

Medications:

Medication	Dose	Times per day	Medication	Dose	Times per day

Allergies:

Medication	Reaction

Vaccinations / Skin Test

Vaccine	Year
Influenza	
Pneumonia	
PPD/TB skin test	

Social History:

History of tobacco use:

Do you smoke: ❒ Cigarettes ❒ Cigars ❒ Neither

If so, how many per day? _____

How many years have you smoked? _____

If you used to smoke, how long ago did you quit? _____

History of Alcohol Use:

Do you consume alcohol? ❒ Yes ❒ No

If so, how many drinks per week? _____

Illicit Drug Use:

Do you use illegal drugs? ❒ Yes ❒ No

If so, what type and how often?

Marital Status:

❒ Single ❒ Married ❒ Divorced ❒ Widowed

Children:

Number of children: _____

Environmental History:

Have you ever been exposed to any harmful substances?

Name of Harmful Substance	# of years

Occupational Information:

List all occupations and how long you worked at each:

Occupation	# of years

Family History:

Family Member	Living	Deceased	Age/Age at death	Health Condition or Cause of Death
Father	☐	☐		
Mother	☐	☐		
Spouse	☐	☐		
Siblings	Age/Age at death		Current Health Condition or Cause of Death	

System Review: (Please check all that apply.)

General: ❑ Fevers ❑ Chills ❑ Night sweats ❑ Weight loss ❑ Weight gain ❑ Headaches

Pulmonary: ❑ Shortness of breath ❑ Cough ❑ Wheezing ❑ Phlegm ❑ Cough up blood

Sleep: ❑ Difficulty in sleeping ❑ Snoring ❑ Morning headaches ❑ Daytime sleepiness ❑ Stop breathing during sleep

Eyes: ❑ Bluriness of vision ❑ Dry eyes ❑ Light sensitivity

ENT: ❑ Decreased hearing ❑ Loss of smell ❑ Runny or stuffy nose ❑ Sinus pain/drainage ❑ Sore throat ❑ Thrush ❑ Hoarseness of voice

Cardiac: ❑ Chest pains ❑ Palpitations ❑ Heart murmur ❑ Leg Swelling

Gastrointestinal: ❑ Nausea ❑ Vomiting ❑ Heartburn ❑ Difficulty to swallow ❑ Abdominal pain ❑ Blood in stool

Genitourinary: ❑ Pain with urination ❑ Blood in urine ❑ Frequent Urinary tract infections

Musculoskeletal: ❑ Joint pain ❑ Joint swelling ❑ Muscle pain ❑ Back pain

Hematology: ❑ Bruise easily ❑ Bleeding disorder ❑ History of blood transfusion ❑ Anemia

Skin: ❑ Rashes ❑ Tattoos ❑ Itching ❑ Skin discoloration

Psychiatric: ❑ Depression ❑ Anxiety ❑ Suicide attempts

Neurological: ❑ Seizures ❑ Paralysis ❑ Dizziness ❑ Numbness/tingling ❑ Memory loss

Signature: _____ **Date:** _____

Print Form Clear Form Save Form