Respiratory Physicians of SW Washington
3920 Capital Mall Drive SW - Suite 304 - Olympia, WA 98502
Phone: 360-754-1739 Fax: 360-236-1450

Medical History

PATIENT LEGAL NAME	BIRTHDATE	AGE	GENDER	TODAYS DATE

WHAT IS THE REASON FOR TODAYS VISIT?

DATE OF ONSET OF SYMPTOMS?

WHO REFERRED YOU TO OUR CLINIC?

MEDICATIONS (Including Inhalers)

MEDICATION NAME	DOSE	FREQUENCY	MEDICATION ALLERGIES
			DO YOU TAKE ASPRIN, COUMADIN OR
			ARTHRITIS MEDICINE? YES NO
			If yes circle one
			IF YOU SMOKE, HOW MANY PACKS/DAY?
			ALCOHOL TYPE & AMOUNT?
			AREYOU ON STEROID PILLS?
			ARE YOU ON OXYGEN? FLOW RATE:

MEDICAL HISTORY (check appropriate boxes)

RESPIRATORY		CARDIOVASCULARY		ALLERGIES		CANCER		CONSTITUTIONAL		UROLOGY	
Asthma		Ankle Swelling		Allergies		Cancer		Fatigue		Blood in Urine	
Bronchitis		Artificial Heart Valve		Hay Fever				High Cholesterol		Difficulty Urinating	
Cough		Chest Pain						Weight Loss		Kidney Disease	
Coughing Up Blood		Dizziness/Fainting								Urinary Disorder	
Emphysema		Heart Attack		**GASTROENTEROLOGY**							
Pneumonia		Heart Disease		Abdominal Pain		**JOINT**					
Short of Breath		Heart Failure		Blood in Stool		Arthritis				**PSYCHOLOGY**	
Trouble Breathing		Heart Murmur		Diarrhea				**HEMATOLOGY**		Anxiety	
Tuberculosis		Hypertension		Difficulty Swallowing				Anemia		Depression	
Wheezing		Irregular Heart		Heartburn				Bleeding Disorder			
		Leg Pain with Walking		Hepatitis		**ENDOCRINOLOGY**					
		Leg Cramps		Intestinal Bleeding		Diabetes				**OTHER**	
		Phlebitis		Jaundice		Hormone Problems		**Neurology**		Aids Exposure	
SLEEP DISORDER		Palpitations		Liver Disease		Menstrual Dysfunction		Headaches		Blood Transfusions	
Sleep Apnea		Rheumatic Fever		Ulcer		Osteoprosis		Neurological Problem		Gout	
Sleeplessness		Scarlet Fever		Vomiting		Sexual Dysfunction		Seizures		Glaucoma	
Snoring		Varicose Veins				Thyroid Disease		Stroke		Pregnant	
										Other (explain below)	

EXPLANATION:

HOSPITALIZATIONS OR SURGERIES

REASON	DATE	REASON	DATE

OVER PLEASE

FAMILY HISTORY (Check box if a relative has had the disease)													
DISEASE	FATHER	MOTHER	BROTHER		SISTER		DISEASE	FATHER	MOTHER	BROTHER		SISTER	
Asthma							Diabetes						
Tuberculosis							Osteoporosis						
Heart Disease							Thyroid Disease						
Hypertension							Kidney Disease						
Stroke							Mental Illness						
Sleep Disorder							Skin Disease						
Severe Drug/Food Allergy							Other:						
Liver Disease							Other:						
Cancer							Other:						
Arthritis							Other:						

ADDITIONAL INFORMATION

SCREENING INFORMATION		
Date of last chest X-ray:		
Date of last flu shot:		
Date of last pneumonia shot:		
Date of last Rectal Exam:		
Date of last PPD (tuberculin skin test):		
Date of last Pulmonary Function Test:		
Have you ever had bone densitometry testing?		
Date of last allergy testing:		
Date of last Mammogram:		
date of last complete physical:		
Recent X-rays:	Where Taken:	Date:
Recent Laboratory Tests:	Type:	Date:
Other Tests: Lung Scan:	Where:	Date:
	Where:	Date:
	Where:	Date:
	Where:	Date:
	Where:	Date:
What other doctors care for you?		
Was this a work related injury?		

NOTICE: We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others, unless you direct us to do so or unless the law authorizes or compels us to do so. With adequate notice, you may see your record or get more information about it at:

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