BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

THORACIC SURGERY HEALTH HISTORY QUESTIONNAIRE

Last Name:	First:	Birthdate:	Gender:

Primary Care Physician:	Other Physician (s):
List all prior and/or current medical conditions:	List all prior surgeries:

Smoke? No Yes How much? What age began? Stopped at age?

E-cigarettes? No Yes Vaping? No Yes

Alcohol use? No Yes How much?

Do you use drugs recreationally? No Yes

Worked in a Mine? No Yes Worked with Asbestos? No Yes

Tuberculosis Exposure No Yes Prior Pneumonia? No Yes

List all occupations:

FAMILY HISTORY: Condition and Relationship to you	**ALLERGIES:** ☐ No known drug allergy
	Do you have an allergy to LATEX? yes no List Allergies and reactions:

MEDICATIONS* (List all medication including: prescribed, over the counter, vitamins and supplements)

Drug Name	Dosage	Instructions (how often taken)	Date prescribed

**Use back of form if you require additional space*

REVIEW OF SYSTEMS: Please check all that apply to you

_____ Cough: (___dry ___bloody ___green ___white)
_____ Chest pain ___ Wheeze ___ Voice change ___ Fever
_____ Shortness of breath when: _____

_____ Angina ___ Chest pain with exertion ___ Shortness of breath with exertion
_____ Prior heart attack (when:_____)
_____ Racing heart out of the blue ___ Diabetes ___ High blood pressure

_____ Seizure ___ Strokes ___Double Vision ___Headache
_____ Numbness ___Paralysis

_____ Difficulty Swallowing ___ Poor appetite ___ Abdominal pain
_____ Blood stools ___ Change in bowel habits
_____ Weight loss (how much/over what period of time:_____)

_____ Kidney problems/failure ___ Urinary difficulty ___ Vaginal discharge
_____ Bleeding problems ___ other sites of infection ___ Skin lesions
_____ Boney pain (where _____) ___ Thyroid disease ___ Depression/Psychiatric)

Signature: _____ Date: _____