# 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:

<table>
<thead>
<tr>
<th>Smoke?</th>
<th>No</th>
<th>Yes</th>
<th>How much?</th>
<th>What age began?</th>
<th>Stopped at age?</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-cigarettes?</td>
<td>No</td>
<td>Yes</td>
<td>Vaping?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Alcohol use?</td>
<td>No</td>
<td>Yes</td>
<td>How much?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you use drugs recreationally?</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worked in a Mine?</td>
<td>No</td>
<td>Yes</td>
<td>Worked with Asbestos?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Tuberculosis Exposure</td>
<td>No</td>
<td>Yes</td>
<td>Prior Pneumonia?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

List all occupations:

**FAMILY HISTORY:** Condition and Relationship to you

**ALLERGIES:**

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)

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage</th>
<th>Instructions (how often taken)</th>
<th>Date prescribed</th>
</tr>
</thead>
</table>

*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:** ___________________________