

THE CENTER
FOR LUNG AND
CHEST SURGERY



102 PARK STREET • GLENS FALLS, NY 12801 • (518) 926-5864 • WWW.GLENSFALLSLUNGANDCHESTSURGERY.COM

HISTORY FORM

Note: *This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.*

PATIENT INFORMATION:

Date of Birth: _____ Today's Date: _____

Last Name: _____ First: _____ Middle: _____

Referring Physician: _____ Primary Care Physician: _____

CHIEF COMPLAINT:

What is the main reason for your visit today? (Describe your problem in detail) _____

PAST FAMILY, MEDICAL, SOCIAL HISTORY:

List all serious illness in your family. (Example: heart disease, cancer, TB, diabetes)

_____	_____	_____
_____	_____	_____
_____	_____	_____

List any personal past illnesses and/or surgery and when they occurred:

Illness/surgery	Date	Illness/Surgery	Date	Illness/Surgery	Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

What medical conditions are you currently being treated for? (Please list all)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you on any Medications: Yes No (If yes, please list all with dosage)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke: Yes No (If yes, how much?) _____ How long? _____

Do you drink: Yes No (If yes, how much?) _____

FEMALE PATIENTS ONLY:

Age of 1st Menstrual Period _____ Date of last Period _____ Age of Menopause _____ No. of Children _____

Age of 1st pregnancy _____ Have you ever used birth control pills? Yes No (If yes, how long?) _____

Any family history of Breast, Ovarian or Colon Cancer? Yes No (If yes, please explain:)

Physician use only:

Physician: _____ Date: _____