

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 1<sup>st</sup> Menstrual Period \_\_\_\_\_ Date of last Period \_\_\_\_\_ Age of Menopause \_\_\_\_\_ No. of Children \_\_\_\_\_

Age of 1<sup>st</sup> 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: \_\_\_\_\_