**DOW PULMONARY AND SLEEP**

 **HEALTH HISTORY FORM**

Name: ………………………………………………. Date of Birth: ………………………. Gender: …………………… Race: ……….

Language: …………………………. Height: ……………………inches. Weight: …………………. Lbs.

Allergies: …………………… ……………………… ……………………….. ………………………. ……………………… …………..

Smoker: ………………………. Alcohol: ……………………….

**Medications,** dosage and frequency: ……………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………………………..

**Pharmacy** Name and location: …………………………………………………………………………………………………………………

**Medical History:** Hypertension…… Diabetes ……. Heart attack…….Heart failure………Cancer…………….

COPD……… Asthma……. High cholesterol……… Arthritis…… Other……………………………………………………

**Surgical History:** Appendectomy……. Tonsillectomy………Coronary bypass ……….. Joint replacement…….

Cholecystectomy………Cesarean section……. Back surgery ……….. other…………………………………………………

**Family History:** Father……………………………………….. Mother…………………………… Spouse…………………………

Sibling………………………………………………………………… Grandparents ……………………………………………………………

**Reason for visit:** ……………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………

**Review of System:** Weight gain/ loss, dry mouth, sore throat, headache, nasal congestion and drainage.

Watery eyes, visual issues. Neck pain, difficulty in swallowing

Hearing loss, ear ache, ear drainage, sinus pain, neck mass.

Cough, shortness of breath at rest, shortness of breath with activity, sputum production, wheezing, blood in sputum.

Chest pain, breast lump.

Epigastric pain, nausea, vomiting, diarrhea, constipation, black stool.

Snoring, fatigue, gasping for breath, insomnia, leg swelling, joint pains, seizure, leg jerks, skin rash, night time frequent urination, depression, low sex drive. Other…………………………………………………………………….

**MAKE SURE TO BRING CD DISCS OF ALL CHEST X RAYS AND CT CHEST IMAGES WITH YOU.**

 Dow pULMONARY CC & SLEEP, PA

 Patient information

Name: ……………… ….. ……………………….. SSN: ………….. Man woman

ADDRESS : ……………………………………………. CITY: ……………… STATE: …..

Zip: …………… Phone: Mobile …………………………. HOME …………………….

DRIVER LICENSE NUMBER: ……………………………..

EMERGENCY CONTACT: …………………………….. PHONE: ………………………….

referring physician: …………………………… PCP: ……………………………..

REASON FOR VISIT: …………………………......

 INSURANCE INFORMATION

INSURANCE: ……………………………………………………………………………………

POLICY NUMBER: …………………………………... GROUP #: ……………………….

Secondary insurance: ………………………………………………………………….

Policy Number…………………………………….. GROUP #: …………………………

 AUTHORIZATIONS

For and inconsideration of the services rendered by dow pulmonary and sleep, pa, i agree to pay said provider of services for all services rendered. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL HEALTH INSURANCE DEDUCTABLE, COPAYMENT, CO-INSURANCE NOT COVERED BY MY INSURANCE POLICY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE POLICY TO INCLUDE, NO SHOW TO THE APPOINTMENT, OUT OF NET WORK PHYSICIAN PROVIDER, NOT MEDICALLY NECESSARY, OUT OF NET WORK FACILITY AND PROCEDURE CHARGES. I HEREBY CONSENT TO RELEASE INFORMATION NECESSARY TO PROCESS CLAIMS WITH MY INSURANCE POLICY, I UNDERSTAND THAT SPECIFIC INFORMATION TO BE RELEASED MAY INCLUDE BUT NOT LIMITED TO HISTORY, DIAGNOSIS, TREATMENT, MENTAL ILLNESS AND COMMUNICABLE DISEASE INCLUDING hiv.

SIGNED:…………………………………………………………… DATE: …………………………………………………….

NAME: ………………………………………………………………………