

Midwest Thoracic Surgeons, P.C.  
**H&P Form**

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Referring physician \_\_\_\_\_

Primary physician/phone \_\_\_\_\_

What is the problem you're being seen for today?  
 \_\_\_\_\_

**1. Please \* if you have had any of the conditions below, and indicate the year of incident or onset.**

| <i>Condition</i>            | * | <i>year</i> | <i>condition</i>         | * | <i>year</i> | <i>condition</i>        | * | <i>year</i> |
|-----------------------------|---|-------------|--------------------------|---|-------------|-------------------------|---|-------------|
| anemia                      |   |             | cirrhosis                |   |             | irregular heart beat    |   |             |
| anesthetic reaction         |   |             | congestive heart failure |   |             | kidney problems         |   |             |
| angina                      |   |             | diabetes                 |   |             | neurologic problems     |   |             |
| arthritis                   |   |             | emphysema                |   |             | phlebitis (blood clots) |   |             |
| asthma                      |   |             | glaucoma                 |   |             | pneumonia               |   |             |
| bleeding problem            |   |             | heart attack             |   |             | <b>radiation</b>        |   |             |
| bronchitis                  |   |             | heart murmur             |   |             | seizures                |   |             |
| cancer (type)               |   |             | hepatitis                |   |             | stroke                  |   |             |
| <b>chemotherapy</b>         |   |             | high blood pressure      |   |             | tuberculosis            |   |             |
| <i>circulation problems</i> |   |             | <i>high cholesterol</i>  |   |             | <i>ulcers</i>           |   |             |

**2. Have any family members had any of the above? If so, who, and which condition?**

\_\_\_\_\_

**3. Please list the medicines (including herbal medicines) you take now, including doses.**

| <i>medication</i> | <i>strength</i> | <i>frequency</i> | <i>medication</i> | <i>strength</i> | <i>frequency</i> |
|-------------------|-----------------|------------------|-------------------|-----------------|------------------|
| 1.                |                 |                  | 6.                |                 |                  |
| 2.                |                 |                  | 7.                |                 |                  |
| 3.                |                 |                  | 8.                |                 |                  |
| 4.                |                 |                  | 9.                |                 |                  |
| 5.                |                 |                  | 10.               |                 |                  |

**4. Please list any medicine allergies you have, and the reaction (if known).**

If no allergies, check here \_\_\_\_\_

| <i>medication</i> | <i>reaction</i> | <i>medication</i> | <i>reaction</i> |
|-------------------|-----------------|-------------------|-----------------|
| 1.                |                 | 3.                |                 |
| 2.                |                 | 4.                |                 |

**5. Please list any operations or hospitalizations you have had, and indicate the year.**

| <i>operation/hospitalization</i> | <i>year</i> | <i>operation/hospitalization</i> | <i>year</i> |
|----------------------------------|-------------|----------------------------------|-------------|
|                                  |             |                                  |             |
|                                  |             |                                  |             |
|                                  |             |                                  |             |
|                                  |             |                                  |             |

**6. If you work outside the home (or are retired), what type of work do you (did you) do?**

\_\_\_\_\_

**7. Marital status (circle one):** Single Married Widowed Divorced

**8. Please check if you:**

- \* have used aspirin, Motrin, Nuprin, Aleve, Plavix, Coumadin, or similar medicine in the last week.
- \* use alcohol. How much, how often? \_\_\_\_\_.
- \* have ever had a problem with alcohol use.
- \* smoke; How many packs per day? \_\_\_\_\_ number of years \_\_\_\_\_
- \* quit smoking. When? \_\_\_\_\_ How long, how much did you smoke? \_\_\_\_\_
- \* traveled recently. Where? \_\_\_\_\_

**9. Do you have:**

| <i>symptom/condition</i>                     | <i>yes</i> | <i>no</i> | <i>symptom/condition</i>                   | <i>yes</i> | <i>no</i> |
|--|------------|-----------|--|------------|-----------|
| rash   |            |           | heartburn                                  |            |           |
| new lumps                                    |            |           | choking when eating, drinking, or at night |            |           |
| headache                                     |            |           | loss of appetite                           |            |           |
| flushing of your face                        |            |           | abdominal pain                             |            |           |
| recent visual changes                        |            |           | urinary problems                           |            |           |
| hoarseness                                   |            |           | new onset of bone pain                     |            |           |
| difficulty swallowing                        |            |           | shoulder/arm pain                          |            |           |
| sore throat                                  |            |           | numbness/tingling in your arm              |            |           |
| swollen glands                               |            |           | swelling in your legs or feet              |            |           |
| cough  |            |           | weakness in your arms or legs              |            |           |
| coughing up blood                            |            |           | depression/mood change recently            |            |           |
| wheezing                                     |            |           | fever                                      |            |           |
| shortness of breath/difficulty breathing     |            |           | night sweats                               |            |           |
| exposure to asbestos or environmental toxins |            |           | excessive thirst/urination                 |            |           |
| angina/chest pain                            |            |           | fatigue                                    |            |           |
| weight loss                                  |            |           | blood clotting problems/easy bruising      |            |           |
| nausea/vomiting                              |            |           |  |            |           |

Height \_\_\_\_\_ Weight \_\_\_\_\_

Patient  
signature \_\_\_\_\_ date \_\_\_\_\_

Exam notes: