SUFFOLK PULMONARY ASSOCIATES

PATIENT NAME: _____ **DOB:**_____

LIST ALL MEDICATIONS: (use other side, if necessary) You may attach a pre-printed list

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YOUR PHARMACY NAME AND LOCATION: _____

ALLERGIES: _____

MEDICAL HISTORY: (list pulmonary problems first):

_____
_____
_____
_____
_____

FAMILY HISTORY:

Lung Cancer: Father Mother
Other Cancer: _____ Father Mother
Emphysema: Father Mother

VACCINES: Flu Vaccine: Yes No Year _____ Pneumonia Vaccine: Yes No Year _____

SOCIAL HISTORY:

Smoking: Yes - How long? _____ # Packs/Day ____ Non-Smoker Quit - When_____

SURGICAL HISTORY: _____
_____

Height: _____ Weight: _____

RACE: White African-American Native American Asian Hispanic Other

ETHNICITY: Hispanic/Latino Not Hispanic/Latino