Robert N Wolfe MD FCCP Andrew S Wachtel MD FCCP Roy Artal MD FCCP
8635 West 3rd ST. #965W, Los Angeles, CA 90048
Tel 310-657-3792 Fax 310-657-3799

Name: _____ Age: _____Date: _____

Cell Phone Number:_____ Email Address:_____

Can we send medical related correspondences to this email address?
[Yes / No] Please Initial:_____

General Medical History

1. What is the main reason you have come to the doctor today?

   _____

   _____

   _____

   _____

2. Please indicate for which of the following **pulmonary** conditions you are currently (*or have ever*) receiving treatment:
   - Pneumonia [Yes / No] Last episode _____
   - Tuberculosis [Yes / No] Age when diagnosed _____
     Treatment _____
   - Have you ever tested positive for the Tb skin test? [Yes / No]
     - Last test _____
   - Asthma [Yes / No] Age when diagnosed _____
   - Emphysema/COPD [Yes / No] Age when diagnosed _____
   - Frequent episodes of bronchitis [Yes / No] Last episode _____
   - Have you ever smoked (□ Never):
     Age when you started smoking? _____
     Age when you quit smoking? _____
     How many packs per day? _____
     When was your last cigarette? _____
   - Have you ever been exposed to asbestos, fumes, dusts, chemicals, respiratory irritants, or other agents which you feel may have harmed your breathing?

     _____

     _____

     _____

   - Nasal allergies [Yes / No]
   - Sinus infections [Yes / No] Last episode _____

Robert N Wolfe MD FCCP Andrew S Wachtel MD FCCP Roy Artal MD FCCP
8635 West 3rd ST. #965W, Los Angeles, CA 90048
Tel 310-657-3792 Fax 310-657-3799

- Have you ever been allergy tested [Yes / No] When _____
- Have you ever received allergy shots or other specific treatments for allergies [Yes / No] When _____
- Have you ever been diagnosed with, OR, have you ever suspected that you suffer from food allergies [Yes / No] Which foods _____
- Acid reflux/GERD/"heart burn" [Yes / No]

3. Please indicate for which of the following **medical** conditions you are currently (*or have ever*) receiving treatment:
   - Heart disease (heart attack, murmurs, arrhythmia, congestive heart failure, other) [Yes *please circle and dates* / No] _____
   - High blood pressure [Yes / No]
   - Diabetes mellitus [Yes / No]
   - Elevated cholesterol [Yes / No]
4. Use the space below to list additional items from your medical history:

_____

_____

_____

_____

_____

_____

_____

_____

5. List all your previous surgeries or operations (□ None):

Operation	Year

Robert N Wolfe MD FCCP Andrew S Wachtel MD FCCP Roy Artal MD FCCP
8635 West 3rd ST. #965W, Los Angeles, CA 90048
Tel 310-657-3792 Fax 310-657-3799

6. What medicines are you presently taking (□ None)?

Medication	Dose	Frequency

7. List **allergies** or **reactions** to any medications (□ None):

Medication	Reaction

Robert N Wolfe MD FCCP Andrew S Wachtel MD FCCP Roy Artal MD FCCP
8635 West 3rd ST. #965W, Los Angeles, CA 90048
Tel 310-657-3792 Fax 310-657-3799

8. Please provide us with your families medical history *(write in siblings and children as needed)*:

Relative	Age Living Deceased	Medical history. Please specifically include a history of allergies, asthma, cancer, heart, or lung disease.
Mother		
Father		
Siblings		
Children		

9. Where were you born? Where else have you lived? When did you move to L.A.?

10. What is your occupation?

11. What is your marital status? Do you have any children?

Robert N Wolfe MD FCCP Andrew S Wachtel MD FCCP Roy Artal MD FCCP
8635 West 3rd ST. #965W, Los Angeles, CA 90048
Tel 310-657-3792 Fax 310-657-3799

12. How much alcohol do you drink per week? Have you every drunk significantly more than this? Have you ever been treated for alcoholism?

13. Have you used any recreational drugs (including marijuana)? Which and when?

14. Any recent travel? Where and when?

15. Any pets or hobbies?

16. Please use the space below to add any additional information from your medical history that you feel is pertinent:

Patient (or Parent/Legal Guardian Signature) Date

Robert N Wolfe MD FCCP Andrew S Wachtel MD FCCP Roy Artal MD FCCP
8635 West 3rd ST. #965W, Los Angeles, CA 90048
Tel 310-657-3792 Fax 310-657-3799

YES	NO		
		GENERAL	
O	O	RECENT WEIGHT CHANGE	
O	O	POOR APPETITE	
O	O	FEVERS	
O	O	CHILLS	
O	O	FATIGUE	
O	O	NIGHT SWEATS	
		EYES	
O	O	BLURRED VISION	
O	O	GLAUCOMA	
O	O	CATARACTS	
O	O	DISCHARGE	
O	O	REDNESS, BURNING, TEARING OR ITCHING	
		EAR, NOSE THROAT	
O	O	HISTORY OF EAR INFECTIONS	
O	O	NASAL DISCHARGE	
O	O	POST-NASAL DRIP	
O	O	SNEEZING	
O	O	ITCHY NOSE OR MOUTH	
O	O	SWOLLEN GLANDS	
O	O	MOUTH SORES	
O	O	HOARSENESS	
O	O	DIFFICULTY SWALLOWING	
O	O	SORE THROAT	
		CARDIO-RESPIRATORY	
O	O	COUGH	
O	O	WHEEZING	
O	O	SPUTUM PRODUCTION	
O	O	COUGHING UP BLOOD	
O	O	SHORTNESS OF BREATH	
O	O	CHEST TIGHTNESS	
O	O	CHEST PAIN	
O	O	ANKLE SWELLING	
		GASTRO-INTESTINAL	
O	O	NAUSEA OR VOMITING	
O	O	DIARRHEA	
O	O	CONSTIPATION	
O	O	CHANGE IN BOWEL HABITS	
O	O	ABDOMINAL PAIN	
O	O	HEARTBURN	
O	O	BLACK STOOL	
O	O	BLOOD FROM RECTUM	
O	O	JAUNDICE OR HEPATITIS	
O	O	PEPTIC ULCER DISEASE	
O	O	GALLSTONES	
		HEMATOLOGY	
O	O	ANEMIA	
O	O	EASY BRUISING OR BLEEDING	
O	O	HISTORY OF TRANSFUSION	

YES	NO		
		GENITO-URINARY	
O	O	KIDNEY OR FLANK PAIN	
O	O	BURNING ON URINATION	
O	O	FREQUENCY OF URINATION	
O	O	GET UP AT NIGHT TO URINATE	
O	O	BLOOD IN URINE	
O	O	HISTORY OF KIDNEY STONES	
O	O	HISTORY OF URINARY INFECTIONS	
		MALE	
O	O	LUMPS IN TESTICLES	
O	O	DIFFICULTY STARTING URINE OR DECREASED FORCE OF STREAM	
O	O	PROSTATE PROBLEMS	
		FEMALE	
O	O	LAST MAMMOGRAM _____	
O	O	POST-MENOPAUSAL	
O	O	LUMPS IN BREAST	
O	O	PREVIOUS BREAST SURGERY	
O	O	HORMONE THERAPY	
		MUSCULOSKELETAL	
O	O	BACK PAIN	
O	O	JOINT SWELLING OR JOINT PAIN	
O	O	VARICOSE VEINS	
		SKIN	
O	O	RASHES	
O	O	NON-HEALING HIVES	
O	O	ITCHING	
O	O	HISTORY OF SKIN CANCER/MELANOMA	
		NEURO-PSYCHIATRIC	
O	O	HEADACHE	
O	O	SEIZURES	
O	O	PARALYSIS	
O	O	NUMBNESS	
O	O	DIZZINESS	
O	O	DEPRESSION	
O	O	PREVIOUS PSYCHIATRIC TREATMENT	
		ENDOCRINE	
O	O	DIABETES	
O	O	LOW BLOOD SUGAR	
O	O	THYROID PROBLEMS	
O	O	RADIATION TO THE NECK, FACE, OR TONSILS	