THE HUXFORD CLINIC
Pulmonary & Sleep Medicine

ALL CLINICS
PATIENT REGIRSTRATION - PAGE 1 OF 3

Date: ____________________________________
Patient Name: ____________________________________
Date of Birth: ____________________________________
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Student ❑ Child
Occupation: ____________________________________
Reason for Visit: ____________________________________
Current Symptoms: ____________________________________
____

Please list the name and city of your PRIMARY PHARMACY
Name: ____________________________________ City: ____________________

Are you taking ANY medications now? (This includes Prescriptions, over the counter, and herbal medications.)
❑ Yes ❑ No

NAME OF MEDICATION	DOSAGE	HOW OFTEN

Are you allergic to any medications: ❑ Yes ❑ No

NAME OF MEDICATION	TYPE OF REACTION

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Social History

Do you use any tobacco products of any kind? ❑ Yes ❑ No How many years? ____________________
Approximately how much? ________________________ How long ago did you quit? ____________
Do you consume alcohol? ❑ Yes ❑ No How many years? ____________________
Approximately how much? ________________________ How long ago did you quit? ____________

Medical History

Have you ever been diagnosed with the following problems? (circle all that apply)

Cancer: Yes No If yes, what kind? ____

Liver Disease	Yes	No	Emphysema	Yes	No
Asthma	Yes	No	HIV	Yes	No
Kidney Disease	Yes	No	Seizures	Yes	No
Anemia	Yes	No	Reflux	Yes	No
Stroke	Yes	No	Ulcerative Colitis	Yes	No
COPD	Yes	No	Heart Attack	Yes	No
Sleep Apnea	Yes	No	Anxiety	Yes	No
High Cholesterol	Yes	No	Diabetes	Yes	No
High Blood Pressure	Yes	No	Hyperthyroidism	Yes	No
Heart Disease	Yes	No	Congestive Heart Failure	Yes	No

Other conditions not listed? ____
____
____

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Please list all surgeries and include dates (approximate):

Procedure/Surgery	Date
______________________	________________
______________________	________________
______________________	________________
______________________	________________

Family History

Does any member of your family have problems with any of the following? If so, please list relationship to patient

	Mother		**Father**	
Heart Disease	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
	Type:_____________		Type _______________	
Deceased	Yes	No	Yes	No
Cause of Death:	________________		Cause of Death: ____________________	