Name نام و نام خانوادگی	Age سن	Sex جنسیت	Date تاریخ

Reason for referral دلیل ارجاع
How long have you had this problem? شما چه مدت این مشکل را داشتید؟

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Medical History
سابقه ی پزشکی

Respiratory & lung problems	◻ Yes: (◻ Asthma, ◻ emphysema, ◻ bronchitis, ◻ COPD) Other: _____ ◻ No
Chronic problems	□ Heart problem □ Diabetes □ Sinus problems □ High cholesterol □ Stomach problems (ulcer, reflux, heartburn) □ High blood pressure □ Other: _____

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Surgery

Have you ever had surgery?	☐ Yes ☐ No
Type of Operation	Approximate Date

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Allergies

Please complete the following table regarding your allergies.

Allergen	Allergy	**Please describe the types of reactions that you have.**
Animals	☐ Yes ☐ No	
Pollen	☐ Yes ☐ No	
Dust	☐ Yes ☐ No	
Food	☐ Yes ☐ No	
Other (please indicate)	☐ Yes ☐ No	

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Medications

Please list all your medications (including inhalers, patches, injections, herbal and natural remedies etc).

Medication	Dose (mg)	Amount consumed (times / day)

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Life Style

A. Did you ever smoke (including: cigars, cigarettes, shisha etc)?

▫ Yes (Please complete the following table)

▫ No

▫ **You have quit smoking (age:____)**	▫ **You are still smoking**
What do/did you smoke?	
How much do/did you smoke?	
Age at which you started:	

B. Do you consume alcohol: ▫ Yes (Please complete the following table) ▫ No

Type of liquor	Amount consumed

C. Recreational street drugs:

Marijuana	◻ Yes ◻ No
Cocaine	◻ Yes ◻ No
Other:_____	◻ Yes ◻ No

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Family Medical History

A. Parents:

	Condition	Health Problems	Cause of Death
Father	◻ Alive (Age__) ◻ Dead (Age__)		
Mother	◻ Alive (Age__) ◻ Dead (Age__)		

B. Siblings:

	Alive Deceased	Serious health problems / cause of death
Brothers	1. ☐ ☐ 2. ☐ ☐ 3. ☐ ☐ 4. ☐ ☐ 5. ☐ ☐	_____ _____ _____ _____ _____
Sisters	1. ☐ ☐ 2. ☐ ☐ 3. ☐ ☐ 4. ☐ ☐ 5. ☐ ☐	_____ _____ _____ _____ _____

C. Children:

	Gender	Alive	Deceased	Health problems / Cause of death
1		☐	☐	
2		☐	☐	
3		☐	☐	
4		☐	☐	
5		☐	☐	
6		☐	☐	

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Work History

A. Please indicate your employment condition.

Employment Condition
☐ Employed
☐ Unemployed
☐ You are disability
☐ Retired

B. Have you ever worked in:

☐ Mine	☐ Mill	☐ Factory	☐ Farm	☐ Barn	☐ Construction
☐	☐	☐	☐	☐	☐

When approximately? ____ How long?_____

What was your job title?_____
_____
_____
_____

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Other Exposures

Have you ever had pets (including birds)?	
▫ Yes (please list)	
▫ No	

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