Dignity Health
Norton Thoracic Institute

Norton Thoracic Institute

PATIENT HISTORY		
Patient name:	DOB:	Today's date:
Reason for your visit to our office:		
Describe your current illness/symptoms:		

SOCIAL HISTORY		
Occupation:	Employer:	Retired ☐
Marital status: Married ☐ Spouses name:		Single ☐ Divorced ☐ Widowed ☐
Primary Language: English☐ Spanish☐ Other:		
Other languages spoken:	**Education level:	
Ethnicity:	Race:	

ALCOHOL CONSUMPTION		
Alcohol use?	Yes ☐	No ☐
Drinks per week? Glasses of Wine ___ Cans of beer ___ Shots of liquor ___ Drinks containing 0.5 oz ___ Other: _____		
Have you ever had more than 4 drinks in a day?	Yes ☐	No ☐
How many times in the last 12 months?	1☐ 2☐ 3☐ 4 ☐ + ___	

TOBACCO USE		
Tobacco use?	Yes ☐	No ☐
If so are you ready to quit?	Yes ☐	No ☐
☐Current tobacco smoker Age started: ____ Packs/day: ___ ☐ Former smoker Age started: ____ Quit date: _____		
Smokeless tobacco use?	Yes ☐	No ☐
☐Current smokeless tobacco smoker: Age started: ____ Frequency: Daily ___ Weekly ___ Monthly ___ ☐ Former smokeless tobacco smoker: Age started: ____ Quit date: _____		

DRUG USE		
Drug use?	Yes ☐	No ☐
Type of drug(s) _____ Age started: ____ Frequency: Daily ___ Weekly ___ Monthly ___ ☐Current use ☐ Former use Quit date: _____		
Comments:		

SOCIAL/SPIRITUAL ASSESSMENT		
Are you being emotionally or physically abused?	Yes ☐	No ☐
Comment:		
Is your care being neglected?	Yes ☐	No ☐
Comment:		
Do you have specific needs or concerns about your illness?	Yes ☐	No ☐
Comment:		
What forms of support to you have? Family ☐ Friends ☐ Faith ☐ Other:		

FAMILY HISTORY

Relationship	Alive?	Alcohol abuse	Arthritis	Asthma	Autoimmune disorder	Cancer	COPD/Emphysema	Diabetes	Heart disease	High Cholesterol	High blood pressure	Kidney disease	Learning disability	Mental illness	Stroke	Vision loss	Other/Comment
Mother	Yes ☐ No ☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Father	Yes ☐ No ☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sister/Brother	Yes ☐ No ☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Child(dren)	Yes ☐ No ☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandparents	Yes ☐ No ☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandparents	Yes ☐ No ☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Other Family History:

MEDICAL HISTORY

☐ Alcoholism	☐ Depression	☐ Memory Problems
☐ Allergies	☐ Diabetes mellitus	☐ Mental Illness:
☐ Anemia	☐ Emphysema	☐ Nerve/muscle disease
☐ Anxiety	☐ Fibromyalgia	☐ Osteoporosis
☐ Arthritis	☐ GERD	☐ Pacemaker
☐ Asthma	☐ Glaucoma	☐ Pneumonia
☐ Blood transfusion	☐ Headaches	☐ Seizures
☐ Cancer:	☐ Heart attack	☐ Sickle cell anemia
☐ Cataracts	☐ Heart murmur	☐ Sleep apnea
☐ Chest pain	☐ High cholesterol	☐ Stroke
☐ CHF	☐ HIV/AIDS	☐ Substance abuse
☐ Clotting disorder	☐ High blood pressure	☐ Transplanted organ
☐ COPD	☐ Implants:	☐ Thyroid disease
☐ Chronic cough	☐ Kidney disease	☐ Tuberculosis
☐ Chronic fatigue	☐ Liver disease	☐ Ulcers
☐ Deafness	☐ Meningitis	☐ Migraines

Other Medical History:

SURGICAL HISTORY		
Please indicate side if applicable	Year	Complications/Comments:
☐ AAA repair		
☐ Appendectomy		
☐ Brain surgery		
☐ CABG		
☐ Cholecystectomy		
☐ Bowel:		
☐ Colon:		
☐ Cosmetic:		
☐ Cataracts		
☐ Fracture		
☐ Hernia:		
☐ Hysterectomy		
☐ Vasectomy		
☐ Joint replacement:		
☐ Spine		
☐ Tonsillectomy		
☐ Tubal ligation		
☐ Prostate		
Other Surgical History:		

MEDICATIONS			
Medication name (include vitamins and over the counter)	Dose	Frequency	Why
Do you use oxygen? Yes ☐ No ☐			

ALLERGIES	
Medication/Food	Reaction

OTHER PROVIDERS: First AND Last name	
Primary care provider:	Pain management:
Digestive Specialist:	Dermatologist:
Endocrinologist:	Oncologist:
Urologist:	Radiation oncologist:
Kidney specialist:	Dentist:
Heart specialist:	Other:
Lung specialist:	Other:
Neurologist:	Other:

Are you interested in signing up for our Patient Portal?	Yes ☐	No ☐

PERSONS INVOLVED IN YOUR CARE

The HIPPA Final Privacy Rule provides you with the right to agree or object to the use or disclosure of information to a family member or close friend who is involved in your care. I understand that **Norton Thoracic Institute** will refuse to discuss my information with anyone NOT listed below, except in an emergency. I also understand that this does not apply to medical providers. I can edit this lest at any time by providing a written request to the practice.

Please print:

Name	Contact number	Relationship

Patient signature: _____ Date: _____