Houston Clinic For Lungevity
Follow Up Patient Form Houston Clinic For Lungevity
2201 W. Holcombe Blvd. STE 320 Houston TX 77030-2042 346-492-6805 630-376-7665

NAME:_____DOB:_____DATE:_____

Please provide your **PAST MEDICAL HISTORY:**

☐Allergies	☐Blood clots	☐MI(heart attack)	☐Diabetes
☐Anemia	☐Cancer, type_____	☐GERD(reflux)	☐CVA(stroke)
☐Anxiety	☐COPD (emphysema)	☐CAD(heart disease)	☐High blood pressure
☐Asthma	☐Eczema	☐Dizziness	☐Atrial Fib
☐Depression	☐Thyroid disease		

Please tell us about any **SURGERIES** you have had, please indicate the date/year if known:

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Date:_____ Surgery:_____

Please provide your **FAMILY HISTORY:**

	Mother	Father	Sister	Brother	Other
Cancer,Type					
Asthma					
Hypertension					
Mental Illness					
Heart Disease					
Diabetes					
Other					

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Please provide your **SOCIAL HISTORY:**

Do you smoke?

☐ yes ☐ no ☐ former

if yes, ☐ light ☐ moderate ☐ heavy

how often:_____

years smoked:_____

Year quit:_____

How many cigarettes a day?_____

How soon after you wake up do you smoke?_____

Have you ever tried to quit?

☐yes ☐ no

Do you drink alcohol?

☐ yes ☐ no ☐ former

How often did you have a drink in the past year?_____

How many drinks did you have on a typical day in the past year?_____

How often did you have 6 or more drinks on one occasion in the past year?_____

Signature:

X_____

Date:

_____