Pulmonologist _____
Date of Visit _____

Washington University Physicians
Washington University School of Medicine in St. Louis

Health Questionnaire

Information about you, your previous health and the health of your family enables our physicians and staff to provide effective and efficient health care. This questionnaire will become part of your medical record and is regarded as confidential communication.

Name: _____
Last First Middle

Address: _____

City: _____

Telephone: Day ( ) _____ Evening ( ) _____

Date of Birth _____

Who referred you to the Division of Pulmonology at Washington University? Please provide name, address and phone number.

_____

_____

_____

What is the primary reason you are seeing a lung specialist?

_____

_____