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New Pulmonary Patient Questionnaire

Name_____
Age _____
Date _____

General Medical History

1. Please list any ***surgeries*** you have had and their approximate dates:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Please list any ***allergies*** to medications:

_____	_____
_____	_____
_____	_____

3. List any prescribed ***medications***:

Medication	***Dose***	***Frequency***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. List any ***over the counter*** or ***alternative medications*** you frequently use:

_____ _____
_____ _____
_____ _____

5. List any major ***medical illnesses*** you have had (e.g. heart or lung problems, ulcers, acid reflux, strokes, high blood pressure, diabetes, congestive heart failure, cancer, thyroid, depression, anxiety, heart rhythm problems, anemia, asthma, emphysema, COPD, sleep apnea):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History

List any ***medical problems*** or ***cause of death*** of your immediate family (blood relatives):

Relative	*Medical Problems*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History

1. What is your present **occupation** _____
   What is your current work schedule _____
2. What **other occupations** have you had _____
   _____
3. Yes No Have you had any risk factors for **AIDS/HIV** (blood transfusions, IV drugs, hemophilia, unprotected sex)
4. Yes No Do you or have you used illicit street **drugs?** If yes, what type: _____
   _____
5. **Marital status** Single Domestic Partner Married Divorced Widowed
6. Yes No Any **children**? If yes, how many _____
7. Yes No Recent **travel** outside of the Midwest over the past year? If yes, where: __
   _____
8. Yes No Exposure to **Tuberculosis?** If yes, to whom _____
9. Yes No Have you had PPD or **Tuberculosis** skin test? Result _____
10. Yes No Have you *ever* **smoked? C**igar Cigarettes Pipe Chewing Tobacco
    How many packs per day *at the most* _____
    How many years *at the most* _____
    When did you quit _____
11. Yes No Have you been exposed to significant **second hand smoke**
    By whom _____
12. Yes No Have you had significant exposure to **birds**, chickens, or bird droppings

13. Yes No Have you had significant **occupational exposure** to dust, fumes, chemicals, asbestos, silica, radon, radiation? _____
14. What type of **pets** do you have _____
15. How many **caffeinated beverages** do you drink in a day _____
16. How much **alcohol** do you consume (beer, wine, liquor) _____
17. Yes No Have you ever been an **alcoholic** in the past?

Review of Systems

Have you recently had any of the following? Circle Yes or No. If unsure, leave blank.

Cardiopulmonary

Yes No Persistent cough If yes answer questions below:
What makes cough worse (Perfume, cold/hot air, grass, exercise, pets)? _____
_____
What time of day is cough worse? Night Day Both
How long have you had a cough? _____
Yes No Have you had dizziness or passed out with cough? (if yes, please circle type)
Yes No Chronic Phlegm/Sputum What color is it _____
Yes No Blood in sputum How long ago _____
Dark or Bright Red_____
How much _____
Yes No Wheezing
What makes wheezing worse? _____
Yes No Chest pain or discomfort
Dull or sharp? _____
Radiation of pain? _____
Other symptoms associated with chest pain _____
_____
Yes No Shortness of breath
Yes No Are you short of breath at rest
Yes No Are you short of breath talking or dressing
Yes No Are you short of breath walking a City Block
Flights of stairs that you can walk _____
Yes No Are you short of breath lying flat
How many pillows do you use to feel comfortable _____
Yes No Swelling of ankles
Yes No Bluish lips or fingers
Yes No Palpitations (funny heart beats)
Yes No Have you been on life support (ventilator) due to your breathing
Yes No Previous X-rays or CAT scans of the chest? If yes, where _____

General

Yes No Tire easily/severe fatigue
Yes No Recent weight change if yes, How much_____
Yes No Night Sweats
Yes No Persistent Fevers if yes, how high _____
Yes No Chills

Skin

Yes No Itch
Yes No Rash if yes, What part of the body _____

Yes No Change in hair, nails, or color if yes, Explain _____

Head/Eyes/Ears/Nose/Throat

Yes No Trouble with vision
Yes No Eye pain/swelling/redness
Yes No Wear glasses/corrective lenses
Yes No Loss of smell
Yes No Nasal obstruction
Yes No Nosebleeds
Yes No Sinus problems
Yes No Post nasal drip
Yes No Sore throat
Yes No Hoarseness
Yes No Sore tongue or gums

Genitourinary

Yes No Increase in frequency of urination
Yes No Frequent night time urination How many times per night _____
Yes No Pain or burning on urination
Yes No Blood in urine

Digestive System

Yes No Change in appetite if yes, Explain _____
Yes No Difficulty swallowing if yes, Solids or liquids or both? _____
Yes No Heartburn
Yes No Indigestion
Yes No Feeling of acid in the throat
Yes No Nausea
Yes No Vomiting
Yes No Vomiting blood or dark coffee grounds
Yes No Rectal bleeding
Yes No Black, tarry stools
Yes No Yellow Jaundice
Yes No Diarrhea
Yes No Severe constipation

Hematology

Yes No Swollen glands if yes, What part of the body _____
Yes No Anemia
Yes No Easy bruising

Allergy/Immunology

Yes No Environmental allergies if yes, To what? _____
Yes No Allergy shots
Yes No Seen an allergist if yes, Who? _____
Yes No "Flu shot" this year
Yes No "Pneumonia shot" in past

Endocrinology

Yes No Thyroid problems
Yes No Adrenal problems
Yes No Excess thirst

Yes No Excess hunger
Yes No Excess sensitivity to cold
Yes No Excess sensitivity to heat

Nervous System

Yes No Severe or New Headaches
Yes No Dizziness
Yes No Fainting
Yes No Convulsions/seizures/fits
Yes No Sleeplessness
Yes No Depression
Yes No Anxiety
Yes No Memory loss
Yes No Poor coordination
Yes No Weakness if yes, What part of the body _____
Yes No Paralysis if yes, What part of the body _____

Sleep

Yes No Loud Snoring
Yes No Excessive sleepiness
Yes No Restless sleep
Yes No Insomnia
Yes No Snort or gasp for air at night
Yes No Stop breathing in sleep
Yes No Morning Headaches
Yes No Drop attacks associated with anger, laughter, or excitement
Yes No Frequent awakenings
Yes No Waking up and unable to move
Yes No Hallucinations

_____
_____
_____
_____

Date Reviewed & Discussed with Patient _____

Physician Signature_____