



# CRITICAL CARE, PULMONARY & SLEEP

A S S O C I A T E S A PROFESSIONAL LLP

## PULMONARY QUESTIONNAIRE (rev 2011)

Information about you helps us understand you and your health concerns. This questionnaire will become part of your medical record and will be regarded as confidential in nature. Please fill in the blank or check the appropriate answer.

**Date Completed:** \_\_\_\_\_ **Name:** \_\_\_\_\_

Birthdate: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

PCP: \_\_\_\_\_

Please list any other physicians you see \_\_\_\_\_

**PHARMACY** \_\_\_\_\_

**OXYGEN/CPAP/DME COMPANY** \_\_\_\_\_

### OPTIONAL

This information is used for research on the occurrence of disease in different racial and ethnic groups

**Race (circle one)** Asian, American Indian or Alaskan native, Black or African American, More than one race, Native Hawaiian, Other Pacific Islander, White/Caucasian, Prefer not to answer

**Ethnicity (circle one)** Hispanic/Latino or not Hispanic/Latino, Prefer not to answer

**Preferred Language** \_\_\_\_\_

**REASON FOR VISIT:** What is the main reason you are seeing a physician today?

### Allergies

Are you allergic to any medications? \_\_\_\_\_

If yes, list the drug and your reaction (rash, hives, shortness of breath, etc) \_\_\_\_\_

Do you have seasonal allergies?

If yes, what season is the worst? \_\_\_\_\_

Have you ever had skin testing for allergies? \_\_\_\_\_

If yes, when and where? \_\_\_\_\_

### Immunizations

Have you had a flu shot? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Have you had a pneumonia vaccine? \_\_\_\_\_ if yes, when? \_\_\_\_\_

Have you had skin testing for TB (ppd)? \_\_\_\_\_

If yes, was it positive or negative? \_\_\_\_\_

**Family Medical History:** Please note any family member that has ever been diagnosed with any of the following: (i.e. grandmother, father, brother, daughter)

Cancer	Lung Disease
Blood Clots	Asthma
Cystic Fibrosis	Tuberculosis (TB)

**Patient Medical History**

Please check all that **apply to you** now or have applied in the past.

Pneumonia		Anemia	
Cystic Fibrosis		Stroke	
Tuberculosis (TB)		Thyroid problems	
Emphysema / COPD		Liver disease	
Bronchitis		Heart attack	
Asthma		Heart murmur	
Cancer (any type)		Rheumatic fever	
Diabetes		Blood Clot/ pulmonary embolus	
Glaucoma			

**Social History:**

Never smoked \_\_\_\_\_

Not smoking presently \_\_\_\_\_ When did you stop smoking? \_\_\_\_\_

Active smoking: Cigarettes \_\_\_\_\_ Cigars \_\_\_\_\_ Pipe \_\_\_\_\_ Marijuana \_\_\_\_\_

How much do you smoke? \_\_\_\_\_

If cigarettes, how many packs do you smoke per day? \_\_\_\_\_

How many years have you smoked? \_\_\_\_\_

Pack years? (Packs smoked per day) x (years as a smoker)

Do you chew tobacco? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Second hand smoke exposure? \_\_\_\_\_ If yes, how often are you exposed?  
Occasionally (minimum) OR Daily (circle one)

Do you drink alcohol? \_\_\_\_\_

If yes, how many drinks each week? \_\_\_\_\_

Do you drink caffeine? \_\_\_\_\_

If yes, how many servings (coffee, tea, cola) per day?

Do you use drugs? \_\_\_\_\_

If yes, please list (i.e. marijuana, cocaine, methamphetamine) \_\_\_\_\_

**Respiratory Review of Systems**

Do you have a swamp cooler?
Do you use a hot tub regularly?
Have you had exposure to mold or water damage in your home?
Have you been exposed to substances at work (i.e. mining, chemicals, dust, etc); if yes, explain:
Have you been exposed to asbestos?
Are you exposed to DOGS, CATS or BIRDS? Circle all that apply
Do you have a cough?
Do you have chest pain?
Do you snore?
Do you have shortness of breath (dyspnea)? If yes, when?
Do you experience sharp chest pains (pleurisy)?

Have you coughed up blood (hemoptysis)?	When?
Do you have a productive cough (sputum production)?	
Do you experience wheezing?	
Do you use a CPAP?	
If you use a CPAP or supplemental oxygen, what medical equipment company do you use?	
Have you traveled out of the state or country in the last year? If so, when and where?	

**GENERAL REVIEW OF SYSTEMS \*\*Please check only those that apply today\*\***

<b>*GENERAL*</b>	
Weight gain	
Weight loss	
Fatigue	
Fever	
Night sweats	
<b>*SKIN*</b>	
Hives	
Itching	
New lesions	
Rash	
<b>*HEENT*</b>	
Hoarseness	
Painful swallowing	
Sore throat	
Seasonal allergies	
Stuffy nose (rhinitis)	
<b>*NECK*</b>	
Neck stiffness	
Swollen glands	
<b>*CARDIOVASCULAR*</b>	
Chest pain	
Fainting (syncope)	
High blood pressure	
Irregular or rapid heartbeat (palpitations)	
Swelling of hands or feet	
<b>*GASTROINTESTINAL*</b>	
Abdominal pain	
GI bleeding	
Diarrhea	

Difficulty swallowing	
Reflux symptoms (i.e. heart burn)	
<b>*MUSCULOSKELETAL*</b>	
Raynaud's phenomenon	
Calf pain	
Cramps	
Joint swelling	
<b>*NEUROLOGICAL*</b>	
Dizziness	
Stroke or mini stroke (focal neurological symptoms)	
Visual changes	
Weakness	
<b>*PSYCHIATRIC*</b>	
Anxiety	
Depression	
<b>*ENDOCRINE*</b>	
Cold intolerance	
Excessive thirst	
Excessive urination	
Heat intolerance	
<b>*HEMATOLOGY*</b>	
Anemia	
Enlarged lymph nodes	
<b>*SLEEP*</b>	
Obstructive sleep apnea	
Insomnia	
Too much sleep (hypersomnia)	

