PULMONARY QUESTIONNAIRE

NAME: __________________________  AGE: ______  DOB: __________________

DATE: __________  REQUESTING PHYSICIAN: __________________________

NOTE: Please help us find out about you by filling out the “Patient” side of this form on pages 1-4. If you don’t know the answer to one of the questions, ask your bed partner if he/she can answer it for you.

PLEASE LEAVE “CLINICIAN” SIDE BLANK.

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>CLINICIAN</th>
</tr>
</thead>
</table>

Why are you here to see a pulmonary (lung) doctor?  CC

_____________________________________

_____________________________________

Check off any lung or breathing problems or symptoms:  HPI

___ Unable to catch your breath
___ Wheezing
___ High blood pressure
___ Heart murmur
___ Unable to sleep laying flat or with one (1) pillow
___ Night sweats
___ Coughed up blood
___ Chest pains or pressure
___ Shortness of breath
___ Dizziness
___ Swollen legs
___ Heart failure
___ Blue lips or fingernails
___ Leg cramps when you walk

Have you ever had:

___ A pulmonary function test or spirometry
___ A pulmonary stress test
___ A bronchoscopy or bronchial/lung biopsy
___ Lung surgery, including removal of a lobe
___ An electrocardiogram
___ Heart surgery
___ Lung cancer
___ Exposure to tuberculosis or had tuberculosis
___ Pneumonia
___ Blood clot

Are you being treated now or have been treated for any illness? Please list them.

1. ___________________________________________  Past Med Hx
2. ___________________________________________
3. ___________________________________________
4. ___________________________________________
5. ___________________________________________

PERSONAL, FAMILY, SOCIAL HISTORY

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### PULMONARY QUESTIONNAIRE

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>CLINICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had any operations? Any injuries?</td>
<td>Past Surg Hx</td>
</tr>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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</tbody>
</table>

Check if any close family member (parents, siblings and Children) have:

- ___ Heart problems
- ___ Diabetes
- ___ Heartburn
- ___ High Blood Pressure
- ___ Cancer
- Other health problems ________________________________

### Marital Status

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>W</th>
<th>D</th>
</tr>
</thead>
</table>

Social Hx

With whom do you live? ____________________________

What is your occupation? ____________________________

What are your leisure activities? ____________________________

What is your education level? ____________________________

Tell us about your risk of lung disease.

Please check if you have:

- ___ Worked around toxic chemicals or substances
- ___ Asbestos exposure
- ___ Ever smoked
- ___ Lived with someone who smokes

Do you exercise (including walking)?

- ___ Yes
- ___ No

Has a close family member had lung cancer, tuberculosis or emphysema?

- ___ Yes
- ___ No

If yes, who? ________________________________

If you are a woman, have you passed menopause (change of life)?

- ___ Yes
- ___ No

If yes, at what age? ________________________________

Do you take estrogen replacement?

- ___ Yes
- ___ No
**PULMONARY QUESTIONNAIRE**

**PATIENT**

Please tell us anything else about your lungs:

________________________________________________

________________________________________________

Do you smoke?  
___ Yes  ___ No
If yes, how may packs per day? ______________________
For how many years? _____________________________
If you no longer smoke, when did you quit? _________

How much alcohol do you drink? __________________

Do you use any recreational drugs?  
___ Yes  ___ No
If yes, list: ____________________________________

Please tell us about your medicines (names, doses or strength, how many times a day). Include over-the-counter medications and medicine that you’ve recently stopped taking:

<table>
<thead>
<tr>
<th></th>
<th>Medicsines</th>
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<tbody>
<tr>
<td>1.</td>
<td>__________________________</td>
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<tr>
<td>2.</td>
<td>__________________________</td>
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<tr>
<td>3.</td>
<td>__________________________</td>
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<td>7.</td>
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<td>9.</td>
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<td>11.</td>
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<td>13.</td>
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<td>14.</td>
<td>__________________________</td>
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<tr>
<td>15.</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

Are you allergic to any medication:  
___ Yes  ___ No
If yes, list medications to which you are allergic & reactions:

<table>
<thead>
<tr>
<th></th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>__________________________</td>
</tr>
<tr>
<td>2.</td>
<td>__________________________</td>
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<td>__________________________</td>
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</tbody>
</table>

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**CLINICIAN**

Health Habits:

MEDICINES, ALLERGIES, VACCINATIONS
# PULMONARY QUESTIONNAIRE

<table>
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</table>

**Do you have hay fever?**

___ Yes  ___ No

If yes, what kind of symptoms do you experience?

________________________________________________________________________

________________________________________________________________________

**Have you had the following vaccinations?**

___ Influenza (Flu Shot) annually
___ Pneumococcal (Pneumonia) Vaccine

**Please circle any symptom you have, so we can find more about it:**

<table>
<thead>
<tr>
<th>REVIEW OF SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of energy; daytime sleepiness, trouble sleeping; Constitutional</td>
</tr>
<tr>
<td>Snoring; loss of appetite; weight changes; fevers HEENT</td>
</tr>
<tr>
<td>Eye problems, such as double or blurred vision; glaucoma; cataracts</td>
</tr>
<tr>
<td>Hearing problems; buzzing or ringing in ears</td>
</tr>
<tr>
<td>Allergies; hay fever</td>
</tr>
<tr>
<td>Sinus problems</td>
</tr>
<tr>
<td>Blood pressure or heart problems Cardiac</td>
</tr>
<tr>
<td>Asthma; tuberculosis Pulmonary</td>
</tr>
<tr>
<td>Stomach problems; heartburn; indigestion; Gastrointestinal</td>
</tr>
<tr>
<td>change in bowel habits</td>
</tr>
<tr>
<td>Urinary problems; frequency, infections; stones; bladder Genito-Urinary</td>
</tr>
<tr>
<td>Men: Prostate problems; night-time urination</td>
</tr>
<tr>
<td>Women: Abnormal menstrual periods; breast lumps; Female Reproductive</td>
</tr>
<tr>
<td>could you be pregnant; recent mammogram, pap smear</td>
</tr>
<tr>
<td>or pelvic exam</td>
</tr>
<tr>
<td>Joint pains, swelling or redness; arthritis; back pain Musculoskeletal</td>
</tr>
<tr>
<td>Muscle aches or tenderness; gout Dermatologic</td>
</tr>
<tr>
<td>Rash, itching or other skin problems Neurologic</td>
</tr>
<tr>
<td>Paralysis (even temporary); numbness; loss of balance;</td>
</tr>
<tr>
<td>Seizures; loss of memory; headaches; stroke;</td>
</tr>
<tr>
<td>Unusual thoughts; nervousness; crying or sadness; Psychiatric</td>
</tr>
<tr>
<td>Suicide attempts; depression</td>
</tr>
<tr>
<td>Thyroid disorder; diabetes; excess thirst or hunger; Endocrinologic</td>
</tr>
<tr>
<td>Frequent urination</td>
</tr>
<tr>
<td>Bleeding; easy bruising; risk factors for HIV; anemia; cancer Hematologic</td>
</tr>
<tr>
<td>Others: ____________________________________________________________</td>
</tr>
</tbody>
</table>

Personally reviewed by me. I agree with or have amended its findings.

________________________________________________________________________

Physician Signature
**PHYSICAL EXAMINATION**

BP ________  PULSE _____  SpO2 ______  RESP _____  T _____

**GENERAL APPEARANCE**

<table>
<thead>
<tr>
<th>N=Normal</th>
<th>A=Abnormal</th>
<th>D=Deferred</th>
<th>Description of Abnormal Findings</th>
</tr>
</thead>
</table>

1) **NOSE**: Mucosa _____  Turbinates _____  Septum

2) **MOUTH**: Mucosa _____  Teeth _____  Gums _____
   - Tongue _____  Palate: Hard _____  Soft _____
   - Tonsils _____  Posterior Pharynx _____

3) **NECK**: Appearance _____  Symmetry _____
   - Tracheal Position _____  Crepitus _____
   - Thyroid _____  JVD _____

4) **RESPIRATORY**: Inspect _____  Symmetry _____
   - Percussion _____  Palpation _____
   - Auscultation _____  Effort _____

5) **HEART**: Apex _____  Heave _____  Thrill _____
   - Sounds _____  Murmur _____  Rub _____

6) **ABDOMEN**: Masses _____  Tenderness _____
   - Liver _____  Spleen _____  Bowel Sounds _____

7) **LYMPH**: Neck _____  Axilla _____  Groin _____
   - Other (Specify) _____

8) **MUSCULOSKELETAL/NEUROLOGIC**: Gait _____
   - Station _____  Strength _____  Atrophy _____
   - Tone _____  Abnormal Movement _____

9) **EXTREMITIES**: Varicosities _____  Edema _____
   - Pulses _____  Temp _____  Tenderness _____
   - Digits _____  Nails _____

10) **SKIN**: Scars _____  Rashes _____
    - Describe ____________________________

11) **NEUROPSYCH**: Oriented _____  Mood _____

---

New Patient  
99201  1-5 Bullet Points  99241  
99202  6-11 Bullet Points  99242  
99203  12-17 Bullet Points  99243  
99204  All Items with Gray Border and 1  99244  
99205  Item in each non-Gray Border  99245  

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PULMONARY QUESTIONNAIRE

MEDICAL DECISION MAKING

DATA REVIEWED:

Lab (Date)
- Hemoglobin __________
- Electrolytes __________
- Other (Specify) __________

Pulmonary Function Test (Date) __________________________________________

Bronchoscopy (Date) ____________________________________________________

Other (List/Date) ________________________________________________________

X-Rays (Date)  
- ________ Chest
- ________ CT Chest
- ________ MRI
- ________ Other (List Type)

Physician Interpretation:

IMPRESSION:

PLAN:  

F/U __________

--- PFT/Spirometry ---
--- V/Q Scan ---
--- Chest X-ray ---
--- Nocturnal Pulse Oximetry
--- Bronchoscopy
--- Lab
--- Pulm Risk Reduction
--- CPEX Level 1  Level 2
--- Other ______________________

__________________________

Physician Signature

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