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.

PATIENT	CLINICIAN

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.

PERSONAL, FAMILY, SOCIAL HISTORY

Past Med Hx

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**

PULMONARY QUESTIONNAIRE

PATIENT	CLINICIAN

Have you ever had any operations? Any injuries? **Past Surg Hx**

1. _____
2. _____
3. _____
4. _____
5. _____

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

___ Heart problems
___ Diabetes
___ Heartburn
___ High Blood Pressure
___ Cancer
Other health problems _____
_____

Marital Status S M W D **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. **RISK FACTORS**
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, tubercolusis 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 | **CLINICIAN**

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: _____

Health Habits:

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:

MEDICINES, ALLERGIES, VACCINATIONS

Medicines

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**
6. **_____**
7. **_____**
8. **_____**
9. **_____**
10. **_____**
11. **_____**
12. **_____**
13. **_____**
14. **_____**
15. **_____**

Are you allergic to any medication:

___ Yes ___ No

If yes, list medications to which you are allergic & reactions:

Allergies

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**

PULMONARY QUESTIONNAIRE

PATIENT	CLINICIAN

Do you have hay fever?
___ Yes ___ No
If yes, what kind of symptoms do you experience?
_____
_____

Have you had the following vaccinations? **Vaccinations**
___ Influenza (Flu Shot) annually
___ Pneumococcal (Pneumonia) Vaccine

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

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

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

_____
Physician Signature

PULMONARY QUESTIONNAIRE

PHYSICAL EXAMINATION

BP _____ PULSE _____ SpO2 _____ RESP _____ T _____

GENERAL APPEARANCE _____

N=Normal A=Abnormal D=Deferred ***Description of Abnormal Findings***

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

2) ***MOUTH:*** **Mucosa _____ Teeth _____Gums _____**
Tongue _____ Pallate: 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) ***EXTREMETIES:*** **Varicosities _____ Edema _____**
Pulses _____ Temp _____ Tenderness _____
Digits _____ Nails _____

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

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

New Patient		Office Consult
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	I tem in each non-Gray Border	99245

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) **Physician Interpretation:**

_____ Chest

_____ CT Chest

_____ MRI

_____ Other (List Type)

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