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.

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

PERSONAL, FAMILY, SOCIAL HISTORY

Past Med Hx

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? _____

RISK FACTORS

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, 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? _____

Health Habits:

How much alcohol do you drink? _____

Do you use any recreational drugs?

___ Yes ___ No

If yes, list: _____

MEDICINES, ALLERGIES, VACCINATIONS

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

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

Are you allergic to any medication:

___ Yes ___ No

Allergies

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

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 Men: Prostate problems; night-time urination	Genito-Urinary
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