# PULMONARY PATIENT QUESTIONAIRE

(please complete prior to your office visit)

Name _____ DOB _____ AGE _____

SSN _____ Primary Care / Referring Doctor _____

**MEDICAL HISTORY:** please check all conditions identified in you or your immediate family members.

| Condition | Self | Family | Condition | Self | Family |
|---|---|---|---|---|---|
| Migraine Headaches | □ | □ | High Blood Pressure | □ | □ |
| Seizures or Convulsions | □ | □ | Stomach Ulcer | □ | □ |
| Stroke | □ | □ | Liver Disease | □ | □ |
| Glaucoma | □ | □ | Colon or Bowel Trouble | □ | □ |
| Allergies | □ | □ | Kidney Disease | □ | □ |
| Asthma | □ | □ | Arthritis | □ | □ |
| Emphysema | □ | □ | Gout | □ | □ |
| Tuberculosis | □ | □ | Thyroid Problems | □ | □ |
| Heart Trouble | □ | □ | Mental Illness | □ | □ |
| Bleeding Problems | □ | □ | Suicide or Attempted Suicide | □ | □ |
| Anemia | □ | □ | Birth Defects | □ | □ |
| Sickle Cell Disease | □ | □ | Cystic Fibrosis | □ | □ |
| Cancer, include Leukemia | □ | □ | Pulmonary Fibrosis | □ | □ |
| Diabetes | □ | □ | Sleep Apnea | □ | □ |

**SOCIAL / PERSONAL HISTORY:** Please complete the following information about yourself

Current Occupation _____ Previous Occupation _____

Highest Level of Education Completed:

Grade: ___ □ High School □ College: ___ years, degree/major _____ □ Post-graduate: _____

Marital status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Partnered

Personal habits: (check all that apply)

□ Current tobacco use: Type: □ Cigarettes □ Cigars □ Pipe □ Smokeless tobacco packs/day: _____ yrs___

□ Former smoker: Amount / Day:_____ Years: _____ Quit Date: _____

□ Exposed to second-hand smoke □ Asbestos □ Chemical fumes □ Coal dust

□ Consume alcohol: Type _____ Amount / day: _____

□ Consume caffeine: Beverage: _____ Amount / day: _____

□ Exercise regularly: Type: _____ Frequency / week: _____

□ Recreational drug use: _____

# P.R.O.S.

**please check any item which describes recent or ongoing symptoms you have or have had**

**General:** □ **None apply**

□ Significant weight loss □ Loss of feeling of well-being □ Fatigue or loss of energy □ Difficulty sleeping
□ Use of prescription weight loss drugs
Comment: _____

**Eyes:** □ **None apply**

□ Blurred vision □ Double vision □ Seeing spots □ Eye pain/irritation □ Need corrective lenses
□ Cataract □ Glaucoma
Comment: _____

**Ear – Nose – Throat:** □ **None apply**

□ Chronic headaches □ Hearing loss □ Ringing in your ears □ Dizziness
□ Chronic nasal congestion □ Recurring sinus infection □ Nose bleeds □ Nasal obstruction
□ Bleeding gums □ Sore throat □ Toothaches □ Breath odor □ Hoarseness
Comments: _____

**Respiratory:** □ **None apply**

□ Shortness of breath □ Cough □ Chest congestion □ Wheezing □ Coughing up blood
□ Choking □ Noisy breathing □ History of pneumonia □ History of or exposure to tuberculosis (TB)
Comment: _____

**Cardiovascular:** □ **None ap**ply

□ Chest pain □ Heart fluttering or racing □ Heart murmur □ Decreased exercise tolerance
□ Awakening due to shortness of breath □ Difficulty breathing when lying down □ Leg swelling
□ Pain in buttocks or legs with exercise □ Sensitivity of hands or feet to temperature changes
Comments: _____

**Breast:** □ **None apply**

□ Breast lump □ Breast pain
Comment: _____

**Gastrointestinal:** □ **None apply**

□ Stomach pain □ Nausea □ Vomiting □ Diarrhea □ Constipation
□ Frequent heartburn □ Indigestion □ Belching or sour taste □ Difficulty swallowing
□ Bloating □ History of hepatitis □ History of yellow jaundice
**Rectal:**
□ Rectal bleeding □ Rectal pain or irritation □ Swelling or hemorrhoids
Comments: _____

**Genitourinary (Men):** □ **None apply**

□ Frequent urination (□ often at night) □ Pain on urination □ Prostate problems
Comment: _____

**Genitourinary (Women):** □ **None ap**ply

□ Frequent urination (□ often at night) □ Frequent urinary infections □ Blood in urine
Comment:_____

**Lymphatic / Hematologic:** □ **None apply**

□ Unusual lymph node swelling □ Painful lymph nodes
□ History of anemia □ Blood clots □ Bruise easily □ Unusual bleeding
Comment: _____

# P.R.O.S.

**Musculoskeletal:** □ **None apply**

□ Limb or joint pain □ Limb or joint deformity □ Limb or joint swelling / stiffness / redness
□ Muscle weakness □ Loss of muscle bulk □ Muscle spasms or twitching
□ Recurring back / neck pain □ Back / neck injury
Comment: _____

**Neurologic:** □ **None apply**

□ Seizures □ Tremors / shakiness □ Unusual clumsiness □ Limb weakness □ Numbness / tingling
□ Stroke □ History of head injury
Comment: _____

**Psychologic / Sleep:** □ **None Apply**

□ Lapse in memory □ Periods of disorientation / confusion □ Difficulty concentrating □ Depression
□ Mood swings □ History of mental illness □ History of physical or mental abuse
□ Snoring □ Daytime sleepiness □ Leg twitching □ Sleep apnea □ Insomnia
Comment: _____

**Skin:** □ **None apply**

□ Itching □ Rash □ Unusual dryness □ Changes in hair □ Changes in pigmentation
Comment: _____

**Endocrine:** □ **None apply**

Unexpected changes in: □ Tolerance to heat □ Tolerance to cold □ Unusual thirst
Comment: _____

**Allergy / Immunology:** □ **None apply**

□ Seasonal allergies □ Frequent or unusual infections (ie. Bronchitis)
□ Sensitivity to specific items: _____
Comment: _____

Please list all medicines you are currently taking or bring them with you when you come:

| Name of Medicine | Dose or strength of Medicine (mg) | How often and when taken |
|---|---|---|
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_____ _____
Patient signature Date