PATIENT INFORMATION SHEET – Page 1 of 2

Pulmonary Associates P.C. Out-Patient Pulmonary Questionnaire

Name: _____ Age _____ S.S. #: _____

1. **List Allergies to Medications – If No Medicine Allergies, Write none.**

_____ _____ _____ _____

2. **List Your Medications – Both Prescription and Over –The-Counter Medicines. Also List Inhalers Here!**

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

3. Past Medical History: Please place a check mark next to your medical problems.

____ COPD	____ Hiatal Hernia	____ Seizures	____ Low Thyroid
____ Emphysema	____ Heart Disease	____ Diabetes	Other Medical Problems (list below)
____ Asthma	____ Heart Attack	____ Stroke	_____
____ Chronic Bronchitis	____ High Blood Pressure	____ Lung Cancer	_____
____ Arthritis	____ Prostate Cancer	____ Breast Cancer	
____ Peripheral Vascular Disease	____ Other Cancer (List Type) _____		

4. Family History: Please place a check mark next to your medical problems that family members have. To the right of the medical problems you check, please write the name (for example: Mother, Father, Brother, Aunt, Grandparent) of the family member.

____ Asthma _____	____ Diabetes _____	Other Family Medical Problems (list below)
____ Heart Disease _____	____ Stroke _____	_____
____ Heart Attack _____	____ Cancer (List kind and family member below)	_____
____ High Blood Pressure _____	_____	_____

5. Surgical History: Please place a check mark next to the kinds of surgeries you have had.

____ Heart Bypass	____ Hernia Repair	Other Surgeries (list below)
____ Angioplasty	____ Carotid Endartectomy	_____
____ Appendix Surgery (appendectomy)	(surgery to clean out plugged	_____
____ Gall Bladder Surgery (cholycystectomy)	neck arteries)	_____
____ Breast Biopsy	____ " C " Section	_____
____ Breast Removal (mastectomy)		_____
____ Uterus Removal (hysterectomy)		_____

6. Social History

Do you smoke (circle) YES NO
If YES, how many packs a day for how long: _____ packs a day for _____ years.
Did you smoke in the past (circle) YES NO
If YES, how many packs a day for how long: _____ packs a day for _____ years.
If Yes, when did you quit? _____ years ago.
How much beer or alcohol do you drink per day _____; how much do you drink per week _____.
Do you use " street " drugs (circle) YES NO ----------> IF YES, what do you use and how often:_____

7. Work History
What do you do/what have you done to make a living?_____

8. Pets and Hobbies - Please List any pets/birds/animals you have or may have had and any hobbies:

_____
_____

(Please turn page)

PULMONARY ASSOCAITES, P.C. OUT PATIENT PULMONARY QUESTIONNAIRE

8. Review of Systems. Please place a check mark next to symptoms or complaints you have at present.

Lungs/Heart:
- ____ Shortness of breath at rest
- ____ Shortness of breath with activity
- ____ Shortness of breath at night
- ____ Shortness of breath when laying flat
- ____ Wheeze at rest
- ____ Wheeze at night
- ____ Wheeze with activity
- ____ Chest Pain (describe type – sharp, burning, heavy constant….below)
  _____
- ____ Cough
- ____ Sputum (describe sputum:_____)
- ____ Frothy Sputum
- ____ Cough with Blood (explain when and how much below, also describe if streaked or bloody)
  _____

Stomach:
- ____ Heartburn (number of times a week = _____ times a week)
- ____ Nausea
- ____ Vomiting
- ____ Loss of appetite
- ____ Weight Loss
- ____ Constipation
- ____ Diarrhea
- ____ Abdominal Cramps

Head/Neck
- ____ Sinus Drainage (if yes, color = _____)
- ____ Sinus Headaches
- ____ Nasal Drainage (if yes, color = _____)
- ____ Nasal Stuffiness

Other
- ____ Sweating at night (night sweats)
- ____ Sweating during the day
- ____ Fevers
- ____ Chills
- ____ Weight loss (_____ pounds over _____ months)
- ____ Leg Swelling

  If Yes, is swelling daily (circle) YES NO; does swelling go away by the morning (circle) YES NO

  How Many Times do you get up to go to the bathroom at night?_____
- ____ Weakness

  If Yes, is weakness all over (circle) YES NO; If not all over, where are you weak?_____
- ____ Dizziness
- ____ Headache
- ____ Difficulty getting to sleep
- ____ Difficulty sleeping
- ____ Feeling tired in the morning
- ____ Snoring
- ____ Sleepy during the day

9. List other symptoms you thing your doctor should know about _____
_____

10. Your main question or concern today is_____