

BSW Pulmonary and Sleep Specialists - Dallas

3600 Gaston Ave, Wadley 751 • Dallas, TX 75246 • Office 469-800-8070 • Fax 469-800-8080

Patient Name: _____ Date of Birth: ____/____/____

Gender: Male Female Marital Status: Married Widowed Divorced Separated Single

Primary Care Doctor (Name, Phone #): _____

Who referred you to our clinic? _____

What is the primary reason you are seeing a lung specialist?

- Do you have SHORTNESS OF BREATH? NO YES If yes, how often: _____
 (Circle all that apply) At Rest Walking Exercise
 - HOW FAR CAN YOU WALK before you are short of breath? _____
 - Do you USE OXYGEN? NO YES (If yes, how much? _____ L/min)
 - What makes your shortness of breath WORSE? **(Circle all that apply)**

Respiratory infections *Irritants (smoke, perfume, etc.)* *Emotions* *Pregnancy*
Medicine (ibuprofen, etc.) *Changes in weather* *Exercise* *Menses* *Thyroid Problems*

- Do you have COUGH? NO YES If yes, how OFTEN? _____
 - Do you cough up MUCUS? NO YES If yes Color _____ Amount: _____
 - Do you cough up BLOOD? NO YES If yes Color _____ Amount: _____

Have you recently experienced: (circle if positive)

- General: Fever Chills Weight Loss / Gain Night Sweats
- HEENT: Dry eyes/mouth Nasal Congestion Runny Nose Hoarseness
- Chest: Palpitations Chest pain with breathing Chest Tightness Wheezing
- Vascular: Swelling in legs
- Renal: Increased urination at night
- GI: Heartburn
- Skin: Skin changes Nail changes Easy bruising
- Sleep: Daytime sleepiness Snoring Wake up short of breath at night Insomnia

Additional problems: _____

MEDICATIONS:

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ALLERGIES TO MEDICATIONS: _____

MEDICAL HISTORY: _____

SURGICAL HISTORY: _____

FAMILY HISTORY OF MEDICAL PROBLEMS: _____

SOCIAL HISTORY:

- **Tobacco use?** **None** **Previous** **Current**
 - What type (cigarette/cigar/chewing): _____
 - How long: _____ Have you tried quitting? **NO** **YES** How? _____
 - When quit: _____
- Alcohol use currently or in the past? **NO** **YES**
 - If yes, how much: _____ What type: _____ How often: _____
- Illegal drug use currently or in the past? **NO** **YES**
 - If yes, how much: _____ What type: _____ How often: _____

EXPOSURE HISTORY:

1. Are you exposed to ANIMALS? Do you have PETS at home? (If YES, what kind?)

2. What is your occupation? _____
3. Have you been exposed to chemicals in the air? YES NO
If YES, what type _____
4. Have you been exposed to Asbestos? YES NO
5. Do you live in the: CITY or COUNTRY (circle one)
6. Have you travelled anywhere recently? If YES, where: _____

PREVIOUS STUDIES: (circle specific type if only one)

1. Chest X-Ray / CT Chest Date/Location: _____
2. Lung Function Tests Date/Location: _____
3. Lung Biopsy / Bronchoscopy Date/Location: _____
4. Allergy Testing Date/Location: _____
6. Sleep Study Date/Location: _____