Pulmonary Health Questionnaire

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

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

_____

When did the symptoms start?

_____

- Do you have SHORTNESS OF BREATH? ☐ YES ☐ NO If yes circle all that apply. At Rest Walking Exercise
  - How far can you walk before you are short of breath? _____
  - Do you USE OXYGEN? ☐ YES ☐ NO (If yes, how much? _____ L/min)
  - Do you wake up with shortness of breath at night? ☐ YES ☐ NO
  - Do you have other symptoms with your shortness of breath i.e. chest pain, wheezing, swelling of legs lightheadedness? _____
  - What makes your shortness of breath Worse? Circle all that apply.

    Respiratory infections | Irritants (smoke, perfume, etc.) | Anxiety/Stress
    Medicine (Ibuprofen, etc.) | Changes in weather | Exercise
    Pregnancy | Speech/Talking | Thyroid Problems
- Do you have a COUGH? ☐ YES ☐ NO If yes circle all that apply. At Rest Walking Exercise
  - Do you cough up MUCUS? ☐ YES ☐ NO **If so** Color: _____ Amount: _____
  - Do you cough up BLOOD? ☐ YES ☐ NO **If so** Color: _____ Amount: _____
  - What makes your cough worse? Circle all that apply.

    Respiratory infections | Irritants (smoke, perfume, etc.) | Speech/Talking
    Medicine (Ibuprofen, etc.) | Changes in weather | Exercise
  - Does anything make your cough better? i.e. drinking water, medications....

    _____
- Do you have a Durable Medical Equipment Company? ☐ YES ☐ NO If So Who? _____
  - What Kind of Equipment? _____

MEDICATIONS (Please List Below): **PHARMACY:** _____

MEDICATION NAME	DOSAGE	SCHEDULE

ALLERGIES:

Are you allergic to any medications? ☐ YES ☐ NO _____

Have you ever taken steroid medications? ☐ YES ☐ NO

What is the longest period of steroid treatment without interruption? _____

What was the usual dosage of dose range? _____

Did you experience any side effects from the steroids? ☐ YES ☐ NO **If yes please describe:**

_____

_____

_____

Pulmonary Health Questionnaire cont'd.

SOCIAL HISTORY:

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

EXPOSURE HISTORY:

- Are you exposed to ANIMALS/Do you have PETS at home? (If YES, what kind?)
  _____
- What is your occupation?
  _____
- Have you been exposed to chemicals in the air? ☐ YES ☐ NO
  If YES, what type? _____
- Have you been exposed to Asbestos? ☐ YES ☐ NO
- Do you live in a CITY or the COUNTRY? CITY COUNTRY
- Have you travelled anywhere recently? If YES, where? _____

PREVIOUS STUDIES:

- If you have had a CHEST X-RAY, when/where: _____
- If you have had a CT scan of the CHEST, when/where: _____
- If you have had LUNG FUNCTION TESTS, when/where: _____
- If you have had LUNG BIOPSY, when/where: _____
- If you have had BRONCHOSCOPY, when/where: _____
- If you have had ALLERGY TESTING, when/where: _____
- If you have had SLEEP STUDY, when/where: _____

FAMILY HISTORY:

RELATIONSHIP	AGE	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH
MOTHER			
FATHER			
SISTER			
BROTHER			
OTHER			

Review of Systems

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

CHECK ALL THAT APPLY

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Night Sweats / Diaphoresis
- ☐ Weakness

SKIN
- ☐ Rash
- ☐ Itching

HENT
- ☐ Headache
- ☐ Hearing Loss
- ☐ Ringing Ear / Tinnitus
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Nose Bleeds
- ☐ Nasal Congestion
- ☐ Stridor
- ☐ Sore Throat

NEUROLOGICAL
- ☐ Dizziness
- ☐ Weakness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory Change
- ☐ Speech Change
- ☐ Focal Weakness
- ☐ Seizure
- ☐ Loss of Consciousness

EYES
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Vomiting
- ☐ Eye Redness

CARDIO VASCULAR
- ☐ Chest Pain
- ☐ Palpitation
- ☐ Shortness of Breath When Lying down
- ☐ Leg Pain with Walking / Claudication
- ☐ Leg Swelling
- ☐ Gasping for Air During Sleep/PND

RESPIRATORY
- ☐ Cough
- ☐ Coughing up Blood / Hemoptysis
- ☐ Sputum Production
- ☐ Shortness of Breath
- ☐ Stridor
- ☐ Wheezing

MUSKOSKELETON
- ☐ Muscle Ache / Myalgia
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Frequent Falls

ENDO / ALLERGY / HEMA
- ☐ Easy Bruise / Bleeding
- ☐ Environmental Allergy

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Nausea
- ☐ Excessive Thirst
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Dark Stool / Melena

GENITOURINARY
- ☐ Pain with Urination / Dysuria
- ☐ Urinary Frequency
- ☐ Blood in Urine / Hematuria
- ☐ Flank Pain

PSYCHOLOGICAL
- ☐ Depression
- ☐ Suicide Ideation
- ☐ Substance Abuse
- ☐ Hallucinations
- ☐ Nervous/Anxious
- ☐ Insomnia
- ☐ Memory Loss

SLEEP
- ☐ Daytime Sleepiness
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wake Short of Breath at Night
- ☐ Insomnia
- ☐ Frequent Urination at Night