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
    - Medicine (Ibuprofen, etc.)
    - Pregnancy
    - Irritants (smoke, perfume, etc.)
    - Changes in weather
    - Anxiety/Stress
    - Exercise
    - Thyroid Problems
    - Speech/Talking

- 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
    - Medicine (Ibuprofen, etc.)
    - Irritants (smoke, perfume, etc.)
    - Changes in weather
    - Speech/Talking
    - Exercise

- Do you have a Durable Medical Equipment Company? □ YES □ NO If so Who?

MEDICATIONS (Please List Below):

PHARMACY: __________________________

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<thead>
<tr>
<th>MEDICATION NAME</th>
<th>DOSAGE</th>
<th>SCHEDULE</th>
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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:

<table>
<thead>
<tr>
<th>RELATIONSHIP</th>
<th>AGE</th>
<th>AGE AT DEATH</th>
<th>STATE OF HEALTH OR CAUSE OF DEATH</th>
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<tbody>
<tr>
<td>MOTHER</td>
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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

HEMT
☐ 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 / Hemothysis
☐ 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