advocare | Pulmonary and Sleep Physicians of South Jersey

Pulmonary Questionnaire

NAME:____ DATE:___________________________

ADDRESS:____

DATE OF BIRTH:____________________________ AGE:________ SEX:________________

HOME PHONE:________________________ WORK:________________________ CELL:_________________________

MARITAL STATUS: SINGLE:____ MARRIED:____ WIDOW(ER):____ DIVORCED:____ SEPARATED:____

Physician who told you to come here:____

Phone #:________________ Address:___________________________________ City/State:______________

Family Physician: ____

Phone #:________________ Address:___________________________________ City/State:______________

What is the reason for your visit?____

____

ALLERGIES:

Allergy:_____________________________ Reaction:___________________________

Allergy:_____________________________ Reaction:___________________________

Allergy:_____________________________ Reaction:___________________________

CURRENT MEDICATIONS:

NAME: **DOSE** **FREQUENCY** **(or give us a list to copy)**

____

____

____

____

____

____

Do you use oxygen? _____ How much: _________________________

If more space is needed, use the back of this page and check here:____

LAST PNEUMONIA VACCINATION:____

LAST INFLUENZA VACCINATION:____

MEDICAL PROBLEMS (Check if **YOU** have had any of the following problems):

____Asthma ____Emphysema ____Diagnosed sleep disorder

____Atrial fibrillation ____Heart attack ____Stroke

____Blood clots ____Heart failure ____Thyroid disease

____Cancer ____Kidney disease ____Valvular heart disease

____Diabetes ____Pulmonary hypertension ____High blood pressure

Other:____

____

____

Past Surgeries: ____
____
____

Do you smoke cigarettes? Yes____ No ____ Quit____ If quit, how long ago?____________

For how many years have you smoked cigarettes?.......... ________ years

How many cigarettes per day? .... ________ cigarettes

Do you use street drugs now? Yes____ No____
Have you used street drugs in the past? Yes____ No____

Do you drink alcohol? Yes____ No____

How many drinks? ___________ per day ___________ per week

Do you drink caffeinated beverages? Yes____ No____

How many caffeinated beverages do you drink per day? (Coffee, tea or soda)________________

Where were you born? ____

Do you have pets in your home? ____

What is your occupation?____

Have you been exposed to chemical, toxins, or asbestos in the past? Yes____ No____

What were the exposures?____

Do you exercise? Yes____ No ____

What kind of exercise and how often?____

What health problems have occurred in your family?

Mother:____ Deceased ☐

Father:____ Deceased ☐

Brother(s):____ Deceased ☐

Sister(s):____ Deceased ☐

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Are you CURRENTLY having any of the following health problems? Please check all that apply.

GENERAL:	✓ **ALL THAT APPLY**
Poor appetite………………………………………………………	____
Recent weight loss (within six months)……………………………	____
Fevers………………………………………………………………	____
Weight gain………………………………………………………..	____
Night sweats	

CARDIOVASCULAR:	
Chest pain…………………………………………………………..	____
Irregular or fast heart beat………………………………………..	____
Swelling in the ankles……………………………………………	____
Wake up short of breath at night so that you sit up during the night……………………………………………..	____
Pain in your legs when walking…………………………………..	____
Have you had a stress test?………………………………………	____

EYES, EARS, NOSE, THROAT:	
Hearing problems…………………………………………………..	____
Sore throat…………………………………………………………..	____
Recurrent sinus infections ………………………………………	____
Hoarseness…………………………………………………………	____
Nasal congestion …………………………………………………..	____
Post nasal drip ……………………………………………………..	____
Runny nose …………………………………………………………	____

RESPIRATORY:	
Diagnosed asthma ……………….………………………………..	____
Cough with phlegm production…………………………………	____
Cough with blood…………………………………………………..	____
Wheezing…………………………………………………………...	____
Shortness of breath with activity…………………………………	____
Shortness of breath at rest………………………………………..	____
Dry cough…………………………………………………………..	____
Hay fever……………………………………………………………	____
Exposure to TB……………………………………………………..	____
If you are being seen for a cough, is it:	
Dry…………………………………………………………………..	____
Are you consistently raising sputum ?……………………………..	____

What triggers the cough:
Time of Day…………………………………………………… ____
Day of Week…………………………………………………… ____
Related to Eating……………………………………………… ____
Time of Year…………………………………………………… ____
Worse when lying down ……………………………………… ____

GI:
Difficulty swallowing solid food……………………………… ____
Difficulty swallowing liquids………………………………… ____
Heartburn……………………………………………………… ____
Ulcers…………………………………………………………… ____
Diarrhea………………………………………………………… ____
Nausea ………………………………………………………… ____
Pain in abdomen……………………………………………… ____
Blood in stools………………………………………………… ____
Constipation…………………………………………………… ____
Change in bowel habits……………………………………… ____
Vomiting………………………………………………………… ____
Coughing with swallowing…………………………………… ____

ENDOCRINE:
Thyroid problems……………………………………………… ____
Diabetes without insulin……………………………………… ____
Diabetes with insulin………………………………………… ____

NEUROLOGIC:
Headaches……………………………………………………… ____
Seizures………………………………………………………… ____
Weakness in arms or legs…………………………………… ____
Previous stroke (s)…………………………………………… ____
Diagnosed Neurological Disorder__________________________________

GENITOURINARY:
Frequent urination…………………………………………… ____
Burning with urination……………………………………… ____
Blood in urine………………………………………………… ____
Difficulty starting to urinate………………………………… ____
Vaginal discharge……………………………………………… ____
Last menstrual period was: ______________________________________

HEMATOLOGIC:
Anemia………………………………………………………… ____

Easy bruising………………………………………………………. ____
Nose bleeds………………………………………………………… ____
Frequent infections……………………………………………… ____
Enlarged lymph nodes/lumps…………………………………… ____
Current or prior cancer….Yes ____. If yes, what type:________________________________

MUSCULOSKELETAL:
Joint pain ………………………………………………………. ____
Arthritis…………………………………………………………. ____
Muscle weakness……………………………………………….. ____
Muscle pain……………………………………………………. ____
Color changes in the fingers when it is cold……………………… ____
Curvature of the spine………………………………………… ____

SLEEP:
Do you have a sleep disorder diagnosed?…………………………. ____
Snoring at night………………………………………………… ____
Stop breathing during sleep……………………………………... ____
Falling asleep during the day at inappropriate times………………. ____
Falling asleep when driving a car or other vehicle………………… ____
Restless legs……………………………………………………. ____

SKIN:
Skin cancer……………………………………………………… ____
Skin rash or lumps……………………………………………… ____

BREAST:
Breast lumps……………………………………………………. ____
Mammograms…………………………………………………… ____
Nipple discharge………………………………………………… ____

PSYCHIATRIC:
Anxiety…………………………………………………………. ____
Depression……………………………………………………… ____
Problems with excessive use of alcohol or street drugs…………… ____

Patient's signature: ______________________________ Date: ______________

Physician's signature: ____________________________ Date: _______________