MEDICAL HISTORY QUESTIONNAIRE

PULMONOLOGISTS, PC

Patient Name: _____ **Today's Date:** _____

Date of Birth:_____**Referring Doctor:**_____

Height: _____ Weight: _____

Date of your most recent:

Chest x-ray: _____ Where: _____
CT Scan: _____ Where: _____
Pulmonary Function: _____ Where: _____
Bloodwork: _____ Where: _____
Flu vaccine: _____
Pneumococcal (Pneumonia) vaccine: _____

Social History:

Smoking: Age started:_____ Age Stopped:_____ Average packs per day_____
Alcohol: Never_____ Occasional _____ Daily _____
Illegal Drugs: Never ___ Past Use ____ Current Use ____ Which drugs _____
Current employment:_____
Past employment:_____
Any exposure to asbestos or other dusts or fumes?_____
Any pets in your home?_____What kind?_____
Anything new at home that could cause breathing problems (new carpet, heating system, mold in basement)?_____
Any hobbies which involve exposure to dust or fumes?_____
Country where you were born:_____Year came to the USA:_____
Travel outside the USA in the past 10 years:_____

Past Surgery or Hospital Admissions:

Date	**Reason**	**Doctor**	**Hospital**

Medications you are currently taking: (Please also include non prescription)

Medication **Dose** **How many times per day**

_____
_____
_____
_____
_____
_____
_____

Medication Allergies:

Medication **Type of Reaction**

_____
_____
_____
_____

Gynecologic History (Females only):

Number of pregnancies: ____ Number of live children _____ Number of miscarriages____

Family Medical History: (Any parents, grandparents, siblings, or children who have Heart Disease, High Blood Pressure, Diabetes, Cancer, Lung Disease, Arthritis, or Kidney Disease)

Relative **Condition**

_____
_____
_____
_____

Doctors you are seeing:

Primary Doctor:_____
Other Specialists:_____
_____
_____
_____

Do you have an Advance Medical Directive (also known as a "Living Will", "Health Care Proxy", or "Health Care Power of Attorney"? _____

If not, are you interested in learning more about having one?_____

Patient Name: _____ **Date:** _____

Past Medical History: Have You Ever Had, or Currently Suffer From:

	NO	YES
		Please describe and give dates
Glaucoma		
Cataracts		
Heart Attack		
Congestive Heart Failure		
Heart Valve Disease		
Rheumatic Fever		
Pneumonia		
Asthma		
Tuberculosis (TB)		
Pleurisy		
COPD		
Ulcers		
Gallstones		
Hepatitis or Jaundice		
Colitis		
Diverticulitis		
Kidney stones		
Other Kidney Disease		
Convulsions (Seizures)		
Stroke or Paralysis		
Movement Disorder		
Diabetes		
Thyroid Disease		
Skin cancer/Melanoma		
Ever have a blood transfusion?		
Ever have psychiatric care?		
Ever take psychiatric medication?		

Patient Name: _____ **Date:** _____

Review of Systems	Most of the time	Occasionally	Never
Constitutional			
Fevers			
Chills			
Sweats			
Weight loss or gain			
Eyes			
Blurred vision			
Double vision			
Spots			
Ears, Nose & Sinuses			
Ringing in ears			
Dizziness			
Ear stuffiness			
Sinus congestion			
Hay Fever			
Mouth and Throat			
Gum Disease			
Wear Dentures			
Trouble swallowing			
Hoarseness of voice			
Cardiovascular			
Angina			
Chest Pain			
Palpitations			
Ankle swelling			
Phlebitis (blood clots)			
Difficulty lying flat at night			
Waking up short of breath			
Respiratory			
Shortness of breath			
Cough			
Sputum (Phlegm)			
Pain taking a Breath			
Coughing blood			
Wheezing			
Bronchitis			
Gastrointestinal			
Indigestion or Heartburn			
Abdominal cramps or pains			
Nausea or vomiting			
Diarrhea			
Blood in stools			
Rectal bleeding			

Patient Name: _____ **Date:** _____

	Most of the time	Occasionally	Never
Genitourinary			
Urinary infections			
Prostate problems			
Urinating at night			
Slowing of urinary stream			
Leakage of urine			
Blood in urine			
Irregular periods			
Heavy Menstrual Bleeding			
Musculoskeletal			
Joint pains			
Which joints			
Joint swelling			
Joint redness or heat			
Muscle weakness			
Back problems			
Muscle pains when walking			
Neurologic			
Fainting spells			
Speech problems			
Balance problems			
Endocrine			
Excessive thirst			
Excessive urination			
Heat or cold intolerance			
Change in voice			
Change in skin			
Skin			
Skin rash			
Change in moles			
Other skin condition			
Hematologic/Lymphatic			
Bleeding tendency			
Easy bruising			
Swollen glands			
Psychiatric			
Depression			
Anxiety			
Difficulty sleeping			

Patient Name:_____ Date: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, as opposed to just feeling tired? This should refer to your usual way of life during the past few weeks or months. Use the following scale to answer these questions:

0 = No chance of dozing off
1 = slight chance of dozing off
2 = moderate chance of dozing off
3 = high chance of dozing off

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting in a public place (for example, theater or Meeting)	_____
Sitting in a car as a passenger for an hour	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch, without any alcohol	_____
Sitting in a car while stopped for traffic	_____

"STOP" SLEEP DISORDERS SCREENING QUESTIONNAIRE

Height_____ Weight_____ Age_____
BMI_____ Collar Size_____ Neck Circ_____

1. **Do you snore loudly enough to be heard through closed doors?**

   Yes_____ No_____

2. **Do you often feel tired, fatigued, or sleepy during daytime?**

   Yes_____ No_____

3. **Has anyone observed you stop breathing while sleeping?**

   Yes_____ No_____

4. **Do you have are you being treated for high blood pressure?**

   Yes_____ No_____

High Risk for OSA: "Yes" to two or more questions; Low Risk: <Two