

PULMONARY HEALTH QUESTIONNAIRE

Name: _____ Date: _____

DOB: _____ Primary Care Physician: _____

History

Brief description of present problem/complaint: _____

Past History

Have you ever had:

_____ Asthma	_____ Emphysema	_____ Pneumonia	_____ Cancer
_____ Tuberculosis	_____ Diabetes	_____ High blood pressure	_____ Stroke
_____ Seizures	_____ Thyroid problem	_____ Liver problems	_____ Ulcers
_____ Kidney problem	_____ Heart attack	_____ Heart problems	_____ Arthritis
_____ Blood clots	_____ Bleeding problems		

Have you ever had **surgery**?

Date: _____ Type of surgery: _____

Date: _____ Type of surgery: _____

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Date: _____ Type of surgery: _____

Social History

Do you smoke? _____ If yes, how much? _____ When did you quit? _____

Do you drink alcoholic beverages? _____ How many drinks per week? _____

Have you ever used marijuana or any other hard drug? _____

Occupation: _____

Marital status: _____ Children? _____

Pets: _____ Any recent travel? _____

Allergies

Are you allergic to any medications? _____

Are you allergic to anything else? _____

Family History

Relationship	Age (if living)	Age at death	State of health or cause of death
Mother			
Father			
Sisters			
Brothers			
Children			

Review of Systems (Please check yes or no)

Yes No

Yes No

General:

_____ Any recent change in your weight
_____ Sleeping problems

_____ Fevers/chills/sweats
_____ Loud snoring

Skin:

_____ Skin rash _____ Itching

_____ Any new skin marks/spots

Head/Eyes/Ears/Nose/Throat:

_____ Visual problems/changes
_____ Itching eyes or nose
_____ Nose bleeds
_____ Hoarseness

_____ Headaches
_____ Drainage from nose
_____ Sore throats
_____ Sinus infections

Respiratory:

_____ Coughing
_____ Wheezing
_____ Frequent colds or bronchitis

_____ Coughing up blood
_____ Shortness of breath

Cardiovascular:

_____ Chest pain
_____ Swelling of feet/ankles
_____ Heart murmur
_____ Palpitations

_____ Heart attack
_____ Irregular heart beat
_____ Short of breath w/ walking
_____ Dizziness

Gastrointestinal:

_____ Nausea/vomiting
_____ Vomiting blood
_____ Constipation
_____ Difficulty swallowing

_____ Abdominal pain
_____ Heartburn/Indigestion
_____ Diarrhea
_____ Bloody/black stools

Genitourinary:

_____ Pain with urination
_____ Frequent urination

_____ Blood in urine
_____ Kidney stones

Musculoskeletal:

_____ Joint pain/swelling
_____ Back pain

_____ Muscle pains
_____ Muscle aches

Neurological:

_____ Numbness
_____ Tremors

_____ Weakness/paralysis
_____ Seizures

Psych:

_____ Depression

_____ Anxiety/panic attacks

Patient signature

Date

Physician review

Date