

Initial Patient Questionnaire

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Reason for your visit today: Check off or briefly describe the reason for your visit today.

- Cough Asthma Abnormal X-ray/CT finding Medical Clearance COPD
 Dyspnea/shortness of breath Low oxygen level Bronchitis Pneumonia

How long have you had this problem?

- Less than 1 month 2-3 months Greater than 3-6 months Greater than 1 yr
 Not applicable

What has helped the problem?

- Not applicable

What makes the problem worse?

- Not applicable

When do you most notice the problem?

- Not applicable

Past Medical History: Please check off any medical problems you have.

- Asthma COPD/Emphysema Sleep Apnea Seasonal allergies Stroke
 Hypertension High Cholesterol Heart failure Heart Attack Osteoarthritis
 Rheumatoid arthritis Sinus Problems Anemia GI bleed Crohn's Disease Colitis
 DVT/PE Diabetes Kidney disease Thyroid problems Cancer GERD/Reflux
 Liver disease/Hepatitis Connective Tissue Disease

Other: _____

Medications (Name, Strength, Frequency): Please include over-the-counter medications

None

Name	Strength	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medication Allergies (with reaction): _____

No Known Drug Allergies

Hospitalizations: Please list the date, facility and reason for all prior hospitalizations

None Most recent hospitalizations first

Date	Facility	Reason for Hospitalization
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Initials: _____

Past Surgical History: Please list date, facility and type of surgery

None Most recent first

Date	Facility	Type of Surgery
1.		
2.		
3.		
4.		
5.		

Do you have any of the following problems with sleep? Check all that apply.

None/ Not applicable

Snoring Gasping awakenings Morning headache

Daytime fatigue Unintentional falling asleep Poor quality sleep

Other _____

Please check off if you have any of the following problems/symptoms.

Respiratory/Lung: None

Cough Sleep disturbance with breathing Snoring Shortness of breath

Sputum production Coughing up blood Wheezing

Other: _____

General/Constitutional: None

Fever Chills Sweats Appetite loss Fatigue Malaise Weight loss

Weight gain

Other: _____

Vision/Ear/Nose/Throat: None

Vision problems Eye pain Light sensitivity Nasal congestion Earache

Nosebleed Sore throat Difficulty swallowing Postnasal drip

Other: _____

Cardiac/Heart: None

Chest pain/pressure Racing/skipping heart beats Lightheadedness

Palpitations Shortness of breath with exertion Swelling of hands or feet

Difficulty breathing when lying down

Other: _____

Initials: _____

Gastrointestinal/Urinary: None

- Indigestion Heart Burn Nausea Vomiting Abdominal pain Bloating
- Diarrhea Constipation Urinary Frequency Urinary urgency
- Problems starting urinary stream
- Other: _____

Musculoskeletal/Skin: None

- Joint pain Joint swelling Back pain Gout Arthritis Muscle aches
- Muscle weakness Skin lesions Itching Rash Skin discoloration
- Other: _____

Neurological: None

- Headaches Poor Balance Memory Problems Numbness Seizure
- Fainting Tingling Dizziness
- Other: _____

Psychiatric: None

- Depression Anxiety Racing thoughts Heat intolerance Cold Intolerance
- Excessive hunger Excessive thirst Unintentional weight changes
- Other: _____

Allergic/Blood Related: None

- Easy bruising Easy bleeding Enlarged lymph nodes
- Seasonal Allergies Hives Recurrent infections
- Other: _____

Occupational History- What types of jobs have you? What industries have you worked in?

Exposure History- Have you been exposed to any of the following? Check all that apply.

- No known exposures
- No animal exposures

- Asbestos Radon Coal dust Animals - which: _____
- Birds Mold Ponds/pools Evaporative cooler Humidifier Hot tub Silica
- Second hand smoke Tuberculosis

Are there any animals in the home, and what type?

Initials: _____

Please list any travel: (Over the past five years within the US, or any travel internationally)

1.
2.
3.
4.
5.

Tobacco history: Do you smoke?

Current Former Never

At what age did you start smoking? _____

At what age did you quit smoking? _____

How much did/do you smoke (at most)? _____ Packs-per-day

Do you drink alcohol?

Yes No

Beer Wine Cocktail

How many drinks per week? _____

Do you use any other inhaled substances (Marijuana)? Other: _____

Yes No

How many times per week? _____

Are your parents living?

Father: Yes No

Mother: Yes No

Family History: Please list any medical problems regarding your:

Mother: None _____

Father: None _____

Siblings: None _____ # of Siblings _____

Children: None _____ # of children _____

If you have Asthma:

How many times per week do you use your rescue inhaler? _____

How many nights per week do you have Asthma symptom? _____

Initials: _____

Flu Vaccine Date: _____

Pneumonia Vaccine Date: _____