Neurology, Sleep & Pulmonary Specialists

Pulmonary Questionnaire

1. **What type of visit are you here for today?**

- ❑ Asthma
- ❑ COPD
- ❑ Hospital ER/Follow up
- ❑ Cough/Shortness of breath
- ❑ Medication Management
- ❑ Other_____

2. **Since your last visit, have you been to any other doctors, ER, hospital or had any other testing performed?**

_____

3. **Do you have any specific concerns that you would like to address with the physician today?**

_____

4. **Have there been any changes to your medications?**

_____

5. **Do you have any problems taking or paying for your medications?**

_____

6. **Are you enrolled in a Lung Cancer Screening Program**? Y/N, If yes where? _____

OFFICE USE ONLY: Height: _____ ft _____ in Current Weight: _____ lbs _____ T

BP:_____ Pulse:_____ RR: _____ Oxygen Saturation:_____

_____ Oxygen Use Y/N Liters per minute_____

Patient Name_____ Date of Birth_____