Neurology, Sleep & Pulmonary Specialists

Pulmonary Questionnaire-New Patient

Please describe your main lung or breathing concern today:

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

Who is your Primary Care Doctor?

_____

Do you see any specialists? If so fill in below:

_____

MEDICAL HISTORY (Do you have any of the following lung problems?)

_____ COPD (Emphysema, chronic bronchitis)
_____ Asthma
_____ Pulmonary embolism
_____ Pulmonary hypertension (blood clot, lung)
_____ Pleural effusion
_____ Lung cancer
_____Other (please explain below)

_____ Sarcoidosis
_____ Pulmonary fibrosis
_____ Pneumonia
_____ Cystic fibrosis
_____ Tuberculosis
_____ Pneumothorax
_____ Asbestosis

Do you have any of the following medical conditions?

____ High blood pressure (HTN)
____ High cholesterol
____ Diabetes
____ Allergies
____ Acid Reflux

_____ Sleep apnea
_____ Coronary artery disease
_____ DVT (blood clots in legs)
_____ Atrial fibrillation (A-FiB)
_____ Congestive heart failure (CHF)

_____ Rheumatoid arthritis
_____ Hypothyroidism
_____ Lupus
_____ Kidney disease

Other medical conditions:

_____

PAST SURGICAL HISTORY (Check box if yes)

- ❑ Chest/Lung surgery (please explain)_____
- ❑ CABG (bypass surgery)
- ❑ Heart valve replacement
- ❑ Cholecystectomy (gallbladder removal)
- ❑ Pacemaker/ICD placement
- ❑ Other_____

Have you received any of the following vaccines? (Circle Yes or No)

- ❑ Prevnar 13 _____ Date
- ❑ Pneumovax _____ Date
- ❑ Flu vaccine Yes/ No _____ Date
- ❑ Tetanus (TDAP) Yes/No Date: _____
- ❑ PPD (TB Test) Yes/No, Have you ever had a Positive PPD? Yes or No Date _____
- ❑ Shingles Shot _____ Date _____

Please check if any immediate blood relatives have had any of the following:

Patient Name_____ Date of Birth_____

Neurology, Sleep & Pulmonary Specialists

PULMONARY QUESTIONNAIRE

- ❑ COPD
- ❑ High Blood Pressure
- ❑ Asthma
- ❑ Sarcoidosis
- ❑ Heart Disease
- ❑ Emphysema
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Lung Cancer
- ❑ Sleep Disorder

Please list any recent ER visit or hospitalization and the reason. (ex. Asthma, COPD)

_____

Have you fallen recently? If so, did you experience any trauma or injury?

_____

Do you have any hobbies or Pets? _____

Medications & Allergies

Allergies:

Please list all CURRENT MEDICATIONS or provide us with a current medication list. We can make a copy for our records. If you need more room, you may use the back of this page. List Medication and how often do you take this medication

Neurology, Sleep & Pulmonary Specialists

PULMONARY QUESTIONNAIRE

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

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

_____ Oxygen Use Y/N Liters per minute_____