Lung Health Questionnaire

Patient Name: _____ Date of Birth: _____Age: _____
Referring Doctor: _____ Primary Care Doctor (if different): _____

Chief complaint that brings you to our office today / main breathing problem:
_____

Questions About Your Medical History:

Please check any medical problems you have:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ GERD/reflux
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Other (please list)

_____
_____
_____
_____

What **Surgeries** have you had? _____
_____

Please list any **Medication Allergies**: _____
_____

Please list all your **Medications and Doses or bring a current list**:

Medication	Dose	Frequency

Family History:	Status	Age	Diseases
Father:	Alive/Deceased	___	_____
Mother:	Alive/Deceased	___	_____
Sibling(s):	Alive/Deceased	___	_____
	Alive/Deceased	___	_____
	Alive/Deceased	___	_____
Son(s):	Alive/Deceased	___	_____
	Alive/Deceased	___	_____
Daughter(s):	Alive/Deceased	___	_____
	Alive/Deceased	___	_____

Social Information

Do you or have you ever smoked:	**Quit?**	**When did you quit?**
• Cigarettes: # _____ pack(s) per day for _____ years	Yes / No	_____
• Cigars: # _____ cigars per day for _____ years	Yes / No	_____

Have you ever been exposed to asbestos? Yes / No
What pets do you have at home? _____

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Do you drink alcohol? ☐ No ☐ Yes - how often do you drink? _____
Do you use any of the following: ☐ Marijuana ☐ Heroine ☐ Cocaine ☐ Other:

Please check any other symptoms you currently have:

General:	☐ Weight gain ☐ Weight loss ☐ Fever ☐ Chills ☐ Fatigue ☐ Other:
Eyes:	☐ Itchy eyes
Ears, Nose, Throat:	☐ Itchy throat ☐ Sore throat ☐ Nasal congestion ☐ Runny nose
	☐ Cough ☐ Coughing up sputum ☐ Other:
Cardiovascular:	☐ Chest pains ☐ Palpitations ☐ Swelling in ankles or legs ☐ Other:
Respiratory:	☐ Wheezing ☐ Shortness of breath ☐ Sputum ☐ Other:
Gastrointestinal:	☐ Heartburn ☐ Diarrhea ☐ Constipation ☐ Blood in stools ☐ Other:
Musculoskeletal:	☐ Joint pains ☐ Joint swelling ☐ Other:
Skin:	☐ New rash ☐ Insect bite ☐ Other:
Neurologic:	☐ Headaches ☐ Dizziness ☐ Difficulty walking ☐ Other:
Psychiatric:	☐ Depression ☐ Anxiety ☐ Other:
Endocrine:	☐ Excessive thirst ☐ Excessive urination ☐ Other:
Heme/Lymph:	☐ Easy bruising ☐ Easy bleeding ☐ Other:

Please check any of the following breathing problems you have:

☐ Allergies	☐ Lung nodule (spot on x-ray)	☐ Sleep disorder: _____
☐ Asbestos exposure	☐ Nasal polyps	☐ Tuberculosis
☐ Asthma	☐ Obstructive sleep apnea	☐ (+) PPD test (TB test)
☐ COPD or Emphysema	☐ Pulmonary embolism	☐ Other lung disease: _____
☐ Cystic fibrosis	☐ Pulmonary hypertension	☐ Prior lung/chest surgery:
☐ Deep venous thrombosis	☐ Sarcoidosis	Explain: _____
☐ Lung cancer	☐ Sinusitis	

Please check any of the following <u>lung symptoms</u> you have:

- ☐ Chest pains
- ☐ Cough
- ☐ Coughing up blood
- ☐ Difficulty with sleep
- ☐ Daytime sleepiness (excessively tired)
- ☐ Frequent awakenings while sleeping
- ☐ Frequent heartburn
- ☐ Leg pains while falling asleep
- ☐ Leg swelling
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Snoring
- ☐ Sputum or mucous
- ☐ Wheezing

Please check any of the following that <u>makes it harder for you to breathe</u>:

- ☐ Cold weather
- ☐ Cold or flu
- ☐ Paint
- ☐ Perfume
- ☐ Runny nose
- ☐ Sinus infections
- ☐ Smoke
- ☐ Stressful events
- ☐ Warm weather
- ☐ Other: _____

Do you have any <u>environmental</u> allergies? **Yes/No** (please circle)

Allergic to what?: _____

Please answer the following questions: *(use a separate sheet as necessary)*

Where were you born? _____
Where did you grow up? _____
Where do you live now? _____
Where have you traveled to recently? _____
Do you currently work? Yes / No
Please list your current and past jobs: _____
_____

Have you ever had a pneumonia shot (Pneumovax)? Yes / No
Do you get a yearly influenza shot (flu shot)? Yes / No

<u>NOTE</u>: Please refrain from wearing perfumes/colognes to our office. Thank you!