

PULMONARY QUESTIONNAIRE

(please complete prior to your office visit)

Name: _____ Date: _____

Primary Care / Referring Physician: _____

Age: _____ Height: _____ Weight: _____

MEDICAL HISTORY: please check all conditions identified in you or your immediate family members.

Condition	Self	Family	Condition	Self	Family
Migraine Headaches	_____	_____	High Blood Pressure	_____	_____
Seizures or Convulsions	_____	_____	Stomach Ulcer	_____	_____
Stroke	_____	_____	Liver Disease	_____	_____
Glaucoma	_____	_____	Colon or Bowel Trouble	_____	_____
Allergies	_____	_____	Kidney Disease	_____	_____
Asthma	_____	_____	Arthritis	_____	_____
Emphysema	_____	_____	Gout	_____	_____
Tuberculosis	_____	_____	Thyroid Problems	_____	_____
Heart Trouble	_____	_____	Mental Illness	_____	_____
Bleeding Problems	_____	_____	Birth Defects	_____	_____
Anemia	_____	_____	Cystic Fibrosis	_____	_____
Cancer, include Leukemia	_____	_____	Pulmonary Fibrosis	_____	_____
Diabetes	_____	_____	Sleep Apnea	_____	_____
Heartburn/GERD	_____	_____	Other: _____		

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:

including "only as needed" medications or attach a copy of your list

Name of Medicine	Strength (mg)	How often and when taken	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL SURGERIES:

YEAR:

_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to any medications? _____

SOCIAL / PERSONAL HISTORY: Please complete the following information about yourself.

Current Occupation _____

Highest Level of Education Completed:

Grade: ___ High School College: ___ years, degree/major _____ Post-graduate: _____

Marital status: Single Married Separated Divorced Widowed Partnered

FAMILY HISTORY:

Children: Number _____ Age(s) _____ Health: _____

Mother: Living: ___ NO ___ YES Age: _____ Health: _____

Father: Living: ___ NO ___ YES Age: _____ Health: _____

Brother(s): Number _____ Age(s) _____ Health: _____

Sister(s): Number _____ Age(s) _____ Health: _____

PERSONAL HABITS: (check all that apply)

Current tobacco use: Type: Cigarettes Cigars Pipe Smokeless tobacco packs/day: _____ yrs _____

Former smoker: Amount / Day: _____ Years: _____ Quit Date: _____

Consume alcohol: Type _____ Amount / day: _____

Consume caffeine: Beverage: _____ Amount / day: _____

Exercise regularly: Type: _____ Frequency / week: _____

Recreational drug use: _____

HAVE YOU EVER BEEN EXPOSED TO:

IF YES, GIVE DETAILS

Second-hand smoke _____ NO _____ YES _____

Asbestos _____ NO _____ YES _____

Chemical fumes _____ NO _____ YES _____

Pets _____ NO _____ YES _____

Carpeting _____ NO _____ YES _____

DO YOU OR HAVE YOU EVER EXPERIENCE(D):

Shortness of breath mild moderate severe with exertion at rest

Cough mild moderate severe productive dry

Chest congestion

Wheezing

Chest tightness

ER visit(s) If yes, approximate date(s): _____

Hospitalization(s) If yes, approximate date(s): _____

History of pneumonia If yes, approximate date: _____

History of or exposure to tuberculosis (TB): If yes, approximate date: _____

Have you had a recent unexplained weight gain? _____ NO _____ YES

Have you had a recent unexplained weight loss? _____ NO _____ YES

If yes, how much and in what length of time: _____

Additional history or comments: _____

Reviewed By: _____