

Pulmonary Disease and Critical Care Associates Health Questionnaire

Patient Name: _____ Date of Visit: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for Visit: _____

Duration of Problem: _____

Which of the following conditions are you currently being or have ever been treated for in the past?

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart disease/murmur/angina | <input type="checkbox"/> COPD | <input type="checkbox"/> Eye disorder/glaucoma |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Lung problems/cough | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Headache/migraine |
| <input type="checkbox"/> Heartburn/acid reflux | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Anemia/bleeding problems | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Swollen ankles/vein problems | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Liver problems/hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers/colitis |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Eating disorder |

Please describe any past or current medical condition for which you have received or are receiving treatment for, that is not listed above:

Immunizations/Vaccinations: Approximate dates of immunizations (or provide immunization record)

Adult

Tetanus (Td or Tdap) _____

Pneumonia _____

Influenza (flu) _____

Last TB screening _____

Zoster (shingles) _____

HPV _____

Have you been tested for hepatitis A, B, or C?

- Yes No

Childhood

Small pox _____

Polio _____

Measles _____

Rubella (common measles) _____

Medication Allergies: Please list any reactions along with the date and type of reaction. No known allergies

1) _____

3) _____

2) _____

4) _____

Advanced Directives: Please select all that apply to you.

- | | | |
|---|---|--|
| <input type="checkbox"/> Complete Living Will | <input type="checkbox"/> Medical Power of Attorney
Appointed | <input type="checkbox"/> Do Not Resuscitate (regarding
resuscitation or life support) |
|---|---|--|

Past Surgical History: Please include year of surgical procedure.

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Family History:

<u>Parents:</u>	<u>Living</u>	<u>Age (or age at death)</u>	<u>Major illnesses / Cause of death</u>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Siblings:

Male # ___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Female # ___	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Social History:

(City/State) Birthplace: _____ Raised in: _____ Current Residence: _____

Marital Status(circle one): Single/Married/Divorced/Widowed Offspring: # sons _____ # daughters _____

Offspring Major Medical Problems: _____

Education(please check): High school Trade School College Post graduate

Profession/Occupational History: _____

Hobbies: _____

Do you exercise regularly? Yes No What type: _____ How often: _____

Do you smoke? Yes No How much: _____ packs/day How long: _____ years

Do you drink alcohol? Yes No How much: _____ drinks/week How long: _____ years

Current or previous drug use(please check): None Heroin Marijuana Cocaine

Methamphetamine Chewing tobacco Other: _____

Systems Review

Please check all that apply to you in the past 3 months:		
General <input type="checkbox"/> No problems <input type="checkbox"/> Weight changes <input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever or chills <input type="checkbox"/> Weakness	<input type="checkbox"/> Unexplained hair loss <input type="checkbox"/> Trouble sleeping
Head/Eyes <input type="checkbox"/> No problems <input type="checkbox"/> Headache <input type="checkbox"/> Vision problems (blurred or loss of vision, etc.)	<input type="checkbox"/> Eye pain <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Head injury <input type="checkbox"/> Cataracts
Ears/Nose/Mouth/Throat <input type="checkbox"/> No problems <input type="checkbox"/> Mouth sores <input type="checkbox"/> Dizziness <input type="checkbox"/> Dental problems <input type="checkbox"/> Deafness	<input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nose bleed <input type="checkbox"/> Sinus pain	<input type="checkbox"/> Hay fever <input type="checkbox"/> Swollen glands (neck/goiter) <input type="checkbox"/> Sore throat/pain when swallowing
Cardiovascular (Heart/blood vessels) <input type="checkbox"/> No problems <input type="checkbox"/> Fainting spells <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart racing <input type="checkbox"/> Sudden shortness of breath at night or when lying down	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Varicose veins <input type="checkbox"/> Blood clots	<input type="checkbox"/> Swelling of legs <input type="checkbox"/> Aching/burning in legs <input type="checkbox"/> Leg pain in calf or thigh
Respiratory (Breathing/lungs) <input type="checkbox"/> No problems <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Night sweats	<input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Painful breathing <input type="checkbox"/> Exposure to tuberculosis

Gastrointestinal (Digestive)	<input type="checkbox"/> No problems	<input type="checkbox"/> Excessive gas	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Pain when swallowing	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Constipation	
<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Stomach pain		
<input type="checkbox"/> Blood in stool			
Genitourinary (Bladder/kidneys)	<input type="checkbox"/> No problems	<input type="checkbox"/> Bladder infection/other infection	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Pain when urinating	<input type="checkbox"/> Blood in urine		
<input type="checkbox"/> More frequent urination (day or night)			
Musculoskeletal	<input type="checkbox"/> No problems	<input type="checkbox"/> Limited motion of arms or legs	<input type="checkbox"/> Numbness, tingling, or weakness in arms or legs
<input type="checkbox"/> Joint pain or stiffness	<input type="checkbox"/> Swelling or redness		
<input type="checkbox"/> Pain in calf or thigh			
Neurological	<input type="checkbox"/> No problems	<input type="checkbox"/> Tingling	<input type="checkbox"/> Arm/leg weakness
<input type="checkbox"/> Chronic migraines	<input type="checkbox"/> Tremor	<input type="checkbox"/> Headaches with vision changes	
<input type="checkbox"/> New headaches	<input type="checkbox"/> Numbness		
<input type="checkbox"/> Problems with memory or speech			
Psychiatric	<input type="checkbox"/> No problems	<input type="checkbox"/> Suicidal or homicidal thoughts	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Seeing or hearing things (hallucinations)		
<input type="checkbox"/> Depression			
Endocrine (Hormones)	<input type="checkbox"/> No problems	<input type="checkbox"/> Increased facial hair (females)	<input type="checkbox"/> Changes in appetite
<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Sensitive to temperature changes	<input type="checkbox"/> Increased urination	
<input type="checkbox"/> Increased thirst			
Hematologic (Blood)	<input type="checkbox"/> No problems	<input type="checkbox"/> Swollen glands (under arms or groin)	<input type="checkbox"/> Bleeding easily
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bruising easily		
<input type="checkbox"/> Blood clots			
Skin	<input type="checkbox"/> No problems	<input type="checkbox"/> Sores or ulcers	<input type="checkbox"/> Other skin rash or sores
<input type="checkbox"/> Changes in hair/nails	<input type="checkbox"/> Rash on palms of hands/soles of feet	<input type="checkbox"/> New or changing moles	
<input type="checkbox"/> Changes in skin or texture			
Allergies	<input type="checkbox"/> No problems	<input type="checkbox"/> Allergic reaction to drugs: _____	
<input type="checkbox"/> Hives/rashes	<input type="checkbox"/> Allergic reaction to foods: _____		
Other:	_____		

SLEEP SYMPTOMS	<input type="checkbox"/> No problems	<input type="checkbox"/> Restless legs
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Daytime sleepiness	<input type="checkbox"/> Headaches
<input type="checkbox"/> Snoring	<input type="checkbox"/> Changes in libido	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Nightmares		

Epworth Sleepiness Scale: Use the following scale to choose an appropriate number for each situation.
0--Would never doze off **1**--Slight chance of dozing off **2**--Moderate chance of dozing off **3**--High chance of dozing off

Situation:	Rating (Circle one):			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting still in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour with no break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

