Name:_____ Date of Birth:_____/_____/_____ Today's Date:_____/_____/_____

Today's Visit

What is the main reason for today's visit, and when did you first notice the problem? _____
_____
_____
What makes it worse or better:_____
_____
Other information about the problem:_____
_____
_____

Current Problems

(Please check box if applies)

☐ *Shortness of Breath*

-Please check which applies to you:

☐ I am not troubled with breathlessness except with strenuous exercise
☐ I get short of breath when hurrying on a flat surface or walking up a slight hill
☐ I walk slower than people of my age on a flat surface because of breathlessness or I have to stop from shortness of breath when walking on my own pace on a flat surface
☐ I stop for breath after walking about 100yards or after a few minutes.
☐ I am too breathless to leave the house and/or breathless on dressing or undressing

-Are you more short of breath: ☐ lying down ☐sitting up ☐ no difference

-Are you short of breath when you run: ☐ Yes ☐ No

-Are your limitation caused by something other than breathing: ☐ Yes ☐ No:_____

-Were you short of breath: ☐ less than 1 yr ago ☐ More than 1 yr ago ☐ > 5 yrs ago ☐ > 10 yrs ago

-Was there an event that started your shortness of breath:_____

☐ *Cough*

-How often do you cough (do not include clearing your throat)?

☐Not at all or rarely
☐Occasionally, but not bothersome
☐Most days
☐Often or in severe attacks that interfere with activity

-How long have you been coughing? _____ Months or Years

-Do your cough at night? ☐ Yes ☐ No

-The cough produces (Check all that apply)

☐ No phlegm ☐ Phlegm ☐ Blood ☐ Other

☐ *Wheezing*

-What makes it better?_____ Worse?_____

-What age did your wheezing, whistling, or chest tightness first occur? _____

-Was there an event that initiated your wheeze? _____

-How frequently do you wheeze? ☐Daily ☐Nightly ☐Few times a week ☐Few times a month ☐Rarely

☐ *Oxygen Use*

-How much oxygen do your use? _____ ☐all the time ☐with exercise ☐with sleep

-What company do you use?_____, How long have you been on Oxygen?_____ yr

☐ *Chest Pain*

-What are you doing when it occurs?_____

-What makes it worse?_____ Better?_____

Patient Name:_____

-Do you have any of the following with chest pain?

☐Shortness of breath ☐Nausea ☐Vomiting ☐Sweating ☐Dizziness

☐ *Sleepiness*

-Please answer the following questions with the numerical response as follows:

0=would never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (i.e. a theater, a meeting)
_____ As a passenger in a car for an hour without a break
_____ Lying down to rest in a the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic

Pertinent History Information

Please check if you have ever been diagnosed with any of the following:

☐ Allergies
☐ Alzheimer's
☐ Anemia
☐ Aneurysm
☐ Anxiety
☐ Arrhythmias
☐ Arthritis
☐ Aspiration
☐ Asthma
☐ Bleeding Disorder
☐ Bronchiectasis
☐ Bronchitis
☐ Cancer
☐ Cardiac Arrest
☐ Cardiac Disease
☐ Colitis
☐ Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Chronic Cough
☐ Cystic Fibrosis
☐ Diabetes
☐ Emphysema
☐ Fissure
☐ GERD
☐ Heart Disease
☐ Heartburn
☐ Hepatitis
☐ Hernia
☐ HIV/AIDS
☐ Hodgkin's Lymphoma
☐ Hyperactive Airway
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Incontinence
☐ Irregular Heartbeat
☐ Kidney Stones
☐ Leukemia
☐ Lung Cancer
☐ Melanoma
☐ Migraines
☐ Neuropathy
☐ Non-Hodgkins Lymphoma
☐ Obesity
☐ Parkinson's Disease
☐ Pleural Effusion
☐ Pleurisy
☐ Pneumonia
☐ Pneumothorax
☐ Pulmonary Embolism
☐ Pulmonary Fibrosis
☐ Pulmonary Hypertension
☐ Raynaud's Phenomenon
☐ Renal Failure
☐ Rheumatic Fever
☐ Rheumatologic Disease
☐ Sarcoidosis
☐ Scleroderma
☐ Scoliosis

Please list any other disorders not listed above:_____

_____

_____

Have you ever been hospitalized as a result of your breathing? ☐Yes ☐ No

If so why?_____

Where?_____

Were you intubated (on life support)? ☐Yes ☐No

Have you ever been to exposed to tuberculosis (TB) or had a positive TB test? ☐Yes ☐No

If yes have you been treated? ☐Yes ☐ No

If not treated, why?_____

Have you ever had chemotherapy? ☐No ☐Yes, for:_____

Have you ever had radiation therapy? ☐No ☐Yes, for:_____

Patient Name:_____

What allergies do you have? (Please check all that apply)

☐ Ace Inhibitors	☐ Aspirin	☐ Iodine/X-ray Dye	☐ Penicillin
☐ Anesthesia	☐ Codeine	☐ Latex	☐ Pet Dander
☐ Antihistamines	☐ Dairy Products	☐ Mold	☐ Prednisone
			☐ Sulfa Drugs

Others:_____

Have you ever had a Tracheostomy? ☐Yes ☐No

Have you ever had lung Surgery? ☐No ☐Yes, what kind?_____

Please list any other surgeries:_____

_____

_____

Have you had a CT Scan of your chest? ☐No ☐Yes, when and where_____

Have you had a sleep study? ☐No ☐Yes, when and where_____

Have you had a stress test? ☐No ☐Yes, when and where_____

Have you had a pulmonary function test (PFT)? ☐No ☐Yes, when and where_____

Have you had a Echocardiogram? ☐No ☐Yes, when andwhere_____

Relative	Age	If Deceased, Age at Death	Medical Conditions and/or Cause of death (include lung cancer, lung disease, rheumatic, autoimmune or vasculitic diseases)
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

In regards to cigarettes/smoking are you a:

☐Never smoker (smoked less than 5 packs of cigarettes during lifetime)

☐Former Smoker: Quit Date:_____ Packs per day _____ for _____ years

☐Current every day smoker: Packs per day _____ for _____ years

☐Current some day smoker: Packs per day _____ for _____ years

☐Current status unknown

Are you interested in quitting? ☐No ☐Yes

Do you smoke marijuana? ☐No ☐Yes, How many years:_____

Patient Name:_____

Have you ever smoked, inhaled, or injected "recreational" or street drugs? ☐No ☐Yes, what_____

Have you used diet pills? ☐No ☐Yes

Have you lived in an old house within the past 10 years? ☐No ☐Yes

Does your current or past home or workplace have any of the following?

☐Humidifier ☐Sauna ☐Hot Tub/Jacuzzi ☐Water Damage ☐Mold ☐Animals ☐Birds, kind_____

Where have you previously lived for greater than 6 months?_____

_____

Outside this country (indicate which countries)?_____

_____

Have you lived or worked in an environment where you were exposed to heavy smoke or dust? ☐No ☐Yes

Occupational History (Include all occupations you've had)

_____ Years Worked_____ Exposures_____

_____ Years Worked_____ Exposures_____

_____ Years Worked_____ Exposures_____

_____ Years Worked_____ Exposures_____

Have you performed any of the following occupations (please check all that apply)?

☐Farm Work ☐Automotive Mechanic ☐Carpenter ☐Painter ☐Welder ☐Laboratory Worker
☐Sand Blaster ☐Insulator ☐Pipe Fitter ☐Vineyard Worker ☐Longshoreman

Have you worked in an of the following locations?

☐Mine ☐Foundry ☐Quarry ☐Railroad ☐Pulp Mill ☐Paper mill
☐Bakery ☐Smelting ☐Plastic Factory ☐Tunnel Construction

Have you ever been exposed to the following at work/home/elsewhere?

☐Birds ☐Feathers ☐Fishmeal ☐Insecticide ☐Fertilizer ☐Beryllium ☐Cobalt
☐Tin ☐Iron Oxide ☐Aluminum ☐Mica ☐Silica ☐Asbestos ☐Coal
☐Cheese ☐Maple Bark ☐Wheat ☐Coffee/Tea ☐Mushroom ☐Oil ☐Sugar Cane
☐Malt ☐Meat ☐Cotton ☐Wood ☐Cork ☐Detergent ☐Pottery
☐Talc ☐Paint ☐Cement ☐Pipes ☐Brakes ☐Tile
☐Oily Nose Drops ☐Industrial cleaning Solution

List any other unusual exposures that you feel might be important to note:_____

_____

_____

Have you ever taken any of the following medications (check all that apply)?

☐ Azathiprine ☐Chlorambucil ☐Colchicine ☐Gold Salts ☐Interferon ☐Methotrexate ☐Penicillamine
☐Prednisone ☐Busulfan ☐Bleomycin ☐Cyclophosphomide ☐Etoposide ☐GMCSF
☐Mitomycin ☐Nilutamide ☐Nitrosoureas ☐Vinblastine ☐Fenfluramine ☐Dexfenfluramine
☐Leukotrine Inhibitors (Singulaire, Accolate) ☐Propylthiouracil ☐Bladder BCG
☐Cephalosporin (Keflex etc) ☐Isoniazid (INH) ☐Macrolide ☐Minocycline
☐Penicillin
☐Nitrofurantoin (Macrodantin) ☐Sulfonamides (TMP/SMX) ☐Amiodarone (Corarone) ☐Hydralazine
☐Captopril (Capoten) ☐Procainamide (Procain SR) ☐Sotolol ☐Azulfidine ☐Sulfasalazine
☐Bromocriptine ☐Carbemazepine (Tegretol) ☐L Tryptophan ☐Phenytoin (Dilantin)

Have you been in the military? ☐No ☐Yes

If Yes: Branch_____, Years Served_____, Job:_____
Countries Deployed:_____
Known Exposures:_____

Patient Name:_____

Have you noticed any of these symptoms (Please circle):

-General:

Weight Loss, Fevers, Chills, Sweats

List Others:_____

-Cardiovascular:

Chest Pain, Irregular or Fast Heartbeat, Swelling of ankles, Sleeping elevated, Wake up short of breath, Pain in legs while walking, elevated cholesterol

List Others:_____

-Eyes, Ears, Nose and Throat:

Blurred Vision, Double Vision, Hearing Problems, Ringing in Ears, Persistent Sore Throat, Hoarseness, Post nasal drip, Sinus Disease, Runny Nose, Sneezing, Dry Eyes, Dry Mouth, Mouth Ulcers

List Others:_____

-Gastrointestinal:

Difficulty Swallowing Solid Foods or Liquids, Heartburn, Ulcers, Diarrhea, Nausea, Vomiting, Pain in Abdomen, Blood in Stools, Vomiting Blood, Reflux

List Others:_____

-Endocrine:

Thyroid Problems, Increased Thirst, Increased Urination, Night Sweats

List Others:_____

-Neurologic:

Headaches, Seizures, Strokes, Dizziness

List Others:_____

-Genitourinary:

Frequent Urination, Burning with Urination, Blood in Urine, Difficulty to start urination, Discharge

List Others:_____

-Hematologic:

Anemia, Easy Bruising, Nose Bleeds, Frequent Infections, Enlarged Lymph nodes, Lumps

List Others:_____

-Musculoskeletal

Joint Pain or Swelling, Muscle Weakness, Muscle Pain, Changes in fingers when cold, Curvature of Spine

List Others:_____

-Sleep:

Snoring at night, Stop Breathing during sleep, Falling asleep during inappropriate times, Falling asleep while driving, Restless Legs

List Others:_____

-Skin:

Skin Cancer, Rash, Lumps, Itching, Changes in Skin, Hand ulcers, Bruising

List Others:_____

-Breast:

Breast Lumps, Nipple discharge

List Others:_____

-Psychiatric:

Anxiety, Depression, Problems with excessive alcohol or street drugs, Post Traumatic Stress Syndrome

List Others:_____

Patient's Signature:_____ Date:_____

Physician's Signature:_____ Date:_____