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

Return Visit Questionnaire

What is the reason for your follow-up visit today? _____

_____

Since your last visit has any medications changed? If so, please list: _____

_____

If you use inhalers/nebulized medications are you using them as prescribed? □ No □ Yes

If you use a rescue inhaler; how often? □ Multiple times per day □ Daily □Weekly □ Rarely

What inhalers/Nebs are you using currently? _____

_____

Have you had any complications with your inhalers? □ Sore Throat □ Thrush □ Hoarseness □ Urinary Retention

Are you using oxygen? □ No □ Yes

□ Daytime, how much _____ □Exertion, how much _____L □ Nighttime, how much _____L

Since your last visit have you been short of breath? □ No □ Yes

If yes, 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

What makes it better?_____

What makes it worse?_____

Do you feel short of breath after: □ One flight □ Two flights □Three of more flights

Do you feel short of breath after: □ 10ft □ 25ft □ 200ft □ 1 Block □ 5 Blocks □ >1 mile

Since your last visit have you been coughing? □ No □ Yes

If yes, is your cough: □ Better □ Worse □ Same □ Dry □ Productive

If productive what color is the phlegm? _____

What makes it better? _____

What makes it worse? _____

Since your last visit have you been wheezing? □ No □ Yes

If yes, is your wheezing: □ Better □ Worse □ Same

What time of the day do you wheeze most? _____

Since your last visit have you been exposed to any of the following?

□ Chemicals □Smoke □Radiation □Chemotherapy □Immunosuppressant Medications

If exposed to something not listed above please list: _____

Since your last visit has there been a change in hobbies, jobs, or places traveled? □ No □ Yes, what _____

Since your last visit have you been told you have a new diagnosis from your PCP or Specialist? □ No □ Yes, what _____

_____

Since your last visit have you had any new surgeries? □ No □ Yes, please list _____

Please list all physicians you would like this visit to be communicated with:

Name:_____ Phone/Fax:_____ Address:_____

Name:_____ Phone/Fax:_____ Address:_____

Patient Name:_____

Review of Systems

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:_____