Sleep and Lung Clinic of Utah

Date: _____

Pulmonary History Questionnaire

Patient Name:	**Patient ID:**	**Age:**	**Birth Date:**	**Height:**	**Weight:**
Primary Care Physician:					
Briefly describe reason for today's visit:					

Medical Problems / Hospitalizations / Surgeries	**Current Medications / Doses**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

Other Medical History: (check box)		**Medication Allergies / Reactions:**		
❑ Chicken Pox	❑ Measles			
❑ Mumps	❑ Malaria			
❑ Pneumonia	❑ Scarlet Fever			
❑ Rheumatic Fever	❑ Whooping Cough	Annual Influenza Vaccines?	❑ Yes	❑ No
❑ Tuberculosis	❑ Last TB Skin Test Date: _____/_____/_____	Pneumovax?	❑ Yes	❑ No

Your Social History:					**Tobacco:**	❑ Cigarettes	❑ Cigars	❑ Pipe
Marital Status:	❑ Single	❑ Married	❑ Widowed	❑ Divorced	_____Packs / day	Age started smoking? _____		
Children:	❑ Yes	❑ No	Number:_____		Age when quit? _____	Still smoking?	❑ Yes	❑ No
Do you keep animals at home?	❑ Yes	❑ No			**Substance Use:**	_____beers / week	_____ glasses wine / week	_____ozs. Hard liquor / week
❑ Cats	❑ Birds	❑ Dogs			❑ Cocaine	❑ Amphetamines	❑ IV Drugs	

Your Family History:				**Employment History:**		
Please check illnesses that have occurred in your blood relatives? (check box, describe and indicate relatives).				Are you working now?	❑ Yes	❑ No
❑ Cholesterol	Relative (s)	❑ Allergies (Type) _____	Relative(s)	What is (or was) your occupation?		
❑ Strokes		❑ Asthma		Have you been exposed to asbestos or dust or strong fumes at work?	❑ Yes	❑ No
❑ Emphysema		❑ Sleep abnormalities (any kind)_____		If "Yes" above, please describe:		
❑ Cystic Fibrosis		❑ Narcolepsy		Do you have: ❑ Living will ❑ Organ Donor Card ❑ Durable Power of Attorney		
❑ Early Emphysema		❑ Problems staying awake				
❑ Tuberculosis		❑ Sleep Apnea				
❑ Cancer (Type) _____		❑ Diabetes		**Travel History / Birthplace:**		
❑ Heart Disease		❑ Hypertension			U.S. (States)	Foreign (Countries)
❑ Heart Attacks		❑ Other significant conditions:		Last Year?		
❑ Heart Rhythm Problems				Last 10 Years?		
❑ Kidney Diseases						
❑ Hepatitis				**Patient Signature:** _____ Date_____		

See Next Page

Sleep and Lung Clinic of Utah Pulmonary Questionnaire Page 2

Patient Name:

Have you ever had: (check)

General
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Fatigue/ Weakness
- ❑ Fever
- ❑ Excessive Sleepiness
- ❑ Heavy Snoring
- ❑ Rash

Head
- ❑ Headache
- ❑ Head Injury

Eyes
- ❑ Vision Changes
- ❑ Last Eye Exam ___/___/___
- ❑ Glaucoma
- ❑ Cataracts

Hearing
- ❑ Hearing Loss
- ❑ Ringing
- ❑ Dizziness
- ❑ Earaches
- ❑ Infection

Nose / Sinuses
- ❑ Frequent Colds
- ❑ Nasal Stuffiness
- ❑ Discharge
- ❑ Hayfever
- ❑ Nosebleeds
- ❑ Sinus Trouble

Neck
- ❑ Lumps

Mouth
- ❑ Sore Throat
- ❑ Bleeding Gums
- ❑ Hoarseness

Breasts
- ❑ Lumps or Nipple Discharge

Lung Problems
- ❑ Cough
- ❑ Sputum
- ❑ Bloody Sputum
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Short of Breath
- ❑ Last Chest X-ray ___/___/___ (date)

Heart Problems
- ❑ High Blood Pressure
- ❑ Chest Pain or Discomfort
- ❑ Breathlessness with Exertion
- ❑ Breathlessness while Lying Flat
- ❑ Swelling of Lower Extremities
- ❑ Heart Attack ___/___/___ (date)
- ❑ Heart Surgery ___/___/___ (date)

Cancer Type _____ When_____

Endocrine
- ❑ Thyroid Trouble
- ❑ Diabetes
- ❑ Excessive Thirst or Hunger

Have you ever had: (check)

Stomach / Intestinal
- ❑ Difficulty Swallowing
- ❑ Painful Swallowing
- ❑ Heartburn
- ❑ Decreased Appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bleeding from the Rectum
- ❑ Hemorrhoids
- ❑ Tarry Black Stools
- ❑ Abdominal Pain
- ❑ Liver or Gallbladder Trouble
- ❑ Hepatitis

Kidneys / Bladder
- ❑ Increased Urine Frequency
- ❑ Increased Urination at Night (___times / night)
- ❑ Burning or Pain with Urination
- ❑ Bloody Urine
- ❑ Difficulty in Starting Urine Stream
- ❑ Urinary Tract Infections
- ❑ Kidney Stones

Male
- ❑ Hernia
- ❑ Testicular Pain
- ❑ Venereal (Sexually Transmitted) Disease
- ❑ Impotence

Female
- ❑ Abnormal Vaginal Bleeding
- ❑ Venereal (Sexually Transmitted) Disease
- ❑ Last Pelvic Exam / Pap Smear _____
- ❑ Last Breast Exam _____
- ❑ Last Mammogram _____

Muscle / Skeletal
- ❑ Muscle or Joint Pains
- ❑ Arthritis
- ❑ Gout
- ❑ Joint Swelling

Skin
- ❑ Rash, Dryness, Itching
- ❑ Psoriasis
- ❑ Exema

Psychiatric
- ❑ History of Psychiatric Hospitalization
- ❑ Depression
- ❑ Anxiety

Blood / Lymph System
- ❑ Anemia
- ❑ Easy Bruising or Bleeding
- ❑ Blood Clots in the Legs or Lungs
- ❑ Transfusions or Transfusion Reactions
- ❑ Swollen Lymph Nodes
- ❑ Lymphoma
- ❑ Leukemia

Neurologic
- ❑ Fainting
- ❑ Seizure
- ❑ Paralysis
- ❑ Stroke
- ❑ Numbness
- ❑ Tingling
- ❑ Brain Tumor

Immunologic
- ❑ Other Allergies _____
- ❑ Lupus
- ❑ Vasculitis

Patient Signature: _____