mana
medical associates

# PULMONARY MEDICINE PATIENT QUESTIONNAIRE

Date _____ Name _____

DOB _____ Age _____

Referring Physician _____

What problem brings you to see us today?

_____

_____

_____

**Have you had any of the following? (**Any left blank will be reported in your medical record as negative.)

- ❑ Shortness of breath
- ❑ Chest pain
- ❑ Dry cough
- ❑ Cough productive of phlegm
- ❑ Coughing up blood
- ❑ Wheezing

## PAST MEDICAL HISTORY

Check any of the following illnesses with which you have been diagnosed and provide details in the space provided. Please answer each question. Any left blank will be considered negative in your medical record.

- ❑ Asthma
- ❑ Blood clot in leg (DVT)
- ❑ Cancer (specific type) _____
- ❑ Cirrhosis
- ❑ Diabetes
- ❑ Congestive heart failure (weak heart, enlarged heart)
- ❑ Gallbladder disease
- ❑ Coronary artery disease (angina, heart attack, heart blockages)
- ❑ Hepatitis
- ❑ Emphysema or chronic bronchitis
- ❑ HIV/AIDS
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ Pneumonia
- ❑ High blood pressure
- ❑ Peptic ulcer disease (stomach ulcers)
- ❑ Pulmonary embolus (blood clot traveled to lung)
- ❑ Sleep apnea
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Thyroid disease (hyperthyroidism, hypothyroidism)

List any other medical illnesses/diagnoses (use back of page if necessary):

_____

_____

_____

_____

**- next page -**

Patient Name _____

## PAST SURGICAL HISTORY:

List all surgeries you have had in the past and their approximate dates:

_____

_____

_____

_____

## MEDICATIONS:

List all medications you currently take. Include dosage and frequency. Please include all inhalers, insulin and over the counter medications.

1. _____Dose _____Times per day_____ How long _____
2. _____Dose _____Times per day_____ How long _____
3. _____Dose _____Times per day_____ How long _____
4. _____Dose _____Times per day_____ How long _____

## IMMUNIZATION HISTORY:

List approximate date of last immunization. Write N/A if you have never had the immunization.

Influenza "flu shot" _____

Pneumovax "pneumonia shot" _____

Tetanus _____

## ALLERGIES: ❑ check if no known drug allergies

List any drugs you cannot take and why (rash, swelling, nausea. etc.)

_____

_____

_____

_____

## FAMILY HEALTH HISTORY:

| | Lung Disease | Heart Disease | Other Illnesses | Cause of Death |
|---|---|---|---|---|
| Mother | _____ | _____ | _____ | _____ |
| Father | _____ | _____ | _____ | _____ |
| Brother(s) | _____ | _____ | _____ | _____ |
| Sister(s) | _____ | _____ | _____ | _____ |
| Children | _____ | _____ | _____ | _____ |

**- next page -**

Patient Name _____

## HABITS:

Did you ever smoke? ❑ Yes ❑ No If yes, when did you start? _____

Do you still smoke? ❑ Yes ❑ No When did you stop? _____

How many packs per day? _____

Do you drink any alcohol currently? ❑ Yes ❑ No

If yes, approximately how much do you drink? _____

Do you have any past history of heavy alcohol use? ❑ Yes ❑ No

Do you have any history of abusing prescribed or non-prescribed drugs? ❑ Yes ❑ No

Which substance(s)? _____

Last time used? _____

Have you ever abused IV drugs? ❑ Yes ❑ No

## SOCIAL HISTORY:

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

How many children do you have? _____

Who should be contacted in case of an emergency? _____

Relationship _____ Phone Number _____

What is your occupation now or prior to retirement? _____

How long at occupation? _____

Have you been exposed to any of the following at work?

❑ Asbestos

❑ Bird Feathers

❑ Silica (sand, sandblasting)

❑ Coal Dust

❑ Chemicals (provide details) _____

_____

_____

**- next page -**

Patient Name _____

## Review of Systems:

Please check if you have had any of the following symptoms or findings recently. Please answer each question. Any left blank will be considered negative in your medical record.

| Yes | No | General |
|---|---|---|
| ❑ | ❑ | Weakness |
| ❑ | ❑ | Fever |
| ❑ | ❑ | Chills |
| ❑ | ❑ | Tend to be too hot |
| ❑ | ❑ | Tend to be too cold |
| ❑ | ❑ | Night sweats |
| ❑ | ❑ | Weight loss |
| ❑ | ❑ | Weight gain |
| ❑ | ❑ | Loss of appetite |
| ❑ | ❑ | Severe fatigue |
| ❑ | ❑ | Thirsty |
| ❑ | ❑ | More hungry than normal |

| Yes | No | Neurologic |
|---|---|---|
| ❑ | ❑ | Frequent headache |
| ❑ | ❑ | Dizziness/vertigo |
| ❑ | ❑ | Lightheadedness |
| ❑ | ❑ | Fainting/passing out |
| ❑ | ❑ | Weakness arms/legs |
| ❑ | ❑ | Numbness arms/legs |
| ❑ | ❑ | Seizures |
| ❑ | ❑ | Paralysis |

| Yes | No | EENT |
|---|---|---|
| ❑ | ❑ | Blurred vision |
| ❑ | ❑ | Color blindness |
| ❑ | ❑ | Hearing problems |
| ❑ | ❑ | Ringing in ears |
| ❑ | ❑ | Nasal congestion |
| ❑ | ❑ | Runny nose |
| ❑ | ❑ | Nosebleeds |
| ❑ | ❑ | Sinus infection |
| ❑ | ❑ | Hoarseness |
| ❑ | ❑ | Mouth Ulcers |
| ❑ | ❑ | Neck Pain |
| ❑ | ❑ | Mass or lump in neck |
| ❑ | ❑ | Sneezing |
| ❑ | ❑ | Post nasal drip |

| Yes | No | Cardiopulmonary |
|---|---|---|
| ❑ | ❑ | Chest pain (w/exertion) |
| ❑ | ❑ | Chest pain (at rest) |
| ❑ | ❑ | Shortness of breath (w/exertion) |
| ❑ | ❑ | Shortness of breath (at rest) |
| ❑ | ❑ | Shortness of breath (lying down) |
| ❑ | ❑ | Palpitations (heart racing) |
| ❑ | ❑ | Irregular heart beat |
| ❑ | ❑ | Wheezing |
| ❑ | ❑ | Cough |
| ❑ | ❑ | Coughing up blood |
| ❑ | ❑ | Pain on deep breathing |
| ❑ | ❑ | Sleep with more than one pillow under your head at night |
| ❑ | ❑ | Swelling in the feet |

| Yes | No | Sleep |
|---|---|---|
| ❑ | ❑ | Difficulty falling asleep |
| ❑ | ❑ | Frequent awakening |
| ❑ | ❑ | Waking up too early |
| ❑ | ❑ | Nightmares |
| ❑ | ❑ | Leg discomfort/restlessness occurring in the evening |
| ❑ | ❑ | Snoring |
| ❑ | ❑ | Severe daytime sleepiness |
| ❑ | ❑ | Interruptions in breathing while asleep |
| ❑ | ❑ | Waking with shortness of breath |

| Yes | No | Gastrointestinal |
|---|---|---|
| ❑ | ❑ | Pain or difficulty swallowing |
| ❑ | ❑ | Heartburn/indigestion (frequent) |
| ❑ | ❑ | Nausea/vomiting |
| ❑ | ❑ | Diarrhea |
| ❑ | ❑ | Constipation |
| ❑ | ❑ | Blood in stools |
| ❑ | ❑ | Dark, tarry stools |
| ❑ | ❑ | Abdominal pain |
| ❑ | ❑ | Vomited blood |
| ❑ | ❑ | Reflux |

| Yes | No | Musculoskeletal |
|---|---|---|
| ❑ | ❑ | Joint pain/swelling |
| ❑ | ❑ | Leg swelling |
| ❑ | ❑ | Back pain |
| ❑ | ❑ | Muscle pain |

| Yes | No | Skin |
|---|---|---|
| ❑ | ❑ | Rash |
| ❑ | ❑ | Breast lump/mass |

| Yes | No | Heme/Onc |
|---|---|---|
| ❑ | ❑ | Easy bruising |
| ❑ | ❑ | Easy bleeding |
| ❑ | ❑ | Anemia |
| ❑ | ❑ | Swollen glands |

| Yes | No | Genitourinary |
|---|---|---|
| ❑ | ❑ | Frequent urination |
| ❑ | ❑ | Burning urination |
| ❑ | ❑ | Blood in urine |
| ❑ | ❑ | Incontinence |
| ❑ | ❑ | Weak urine stream |
| ❑ | ❑ | Discharge |
| ❑ | ❑ | Heavy menstrual bleeding |
| ❑ | ❑ | Impotence |

| Yes | No | Psychiatric |
|---|---|---|
| ❑ | ❑ | Depression |
| ❑ | ❑ | Anxiety |

I personally reviewed all the systems listed above. _____ Signature _____ Date

## APPOINTMENT CANCELLATION POLICY

MANA Pulmonary Medicine requires a 24-hour notice of cancellation of appointments. Please note there will be a **$50.00 fee** charged to the patient if the appointment is not cancelled 24-hours prior.

If you have an emergency, please let us know and the fee may be waived.

I have read and understand this policy.

PRINT NAME: _____ D.O.B.: _____

PATIENT SIGNATURE: _____ DATE: _____

HOME PHONE #_____ CELL PHONE # _____

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