

Pike Medical Consultants

Pulmonary History Questionnaire

Like most physician groups, our practice uses a history form for first-time patients. We have designed this questionnaire for the specifics of our practice. This form should serve three functions:

1. Act as a checklist to make certain that important questions are always asked
2. Improve the quality of the history by giving you time to recall important details
3. Save time during the office visit

Do not be put off by the apparent length of the questionnaire. There is a lot of empty space for the doctor to write in. Also, you will probably be able to skip some portions of the form. We hope you will find the form to be self-explanatory. If there is a question that you do not understand, please leave it blank and put a question mark in the left-hand margin.

YOUR NAME _____
FIRST MIDDLE LAST

DATE OF BIRTH ____ / ____ / ____ AGE (How old are you today?) _____

OTHER PHYSICIANS YOU'VE SEEN:

What is the name of the physician who referred you? _____

Where does this referring physician practice?

Indianapolis Other City _____

Is the referring physician your **primary doctor** (the physician you see for your usual, overall medical care)?

NO *If NO, what is your primary doctor's name? _____*
Where does your primary doctor practice? _____

YES

Are there other doctors, not listed above, that you see on a regular basis who might be interested in knowing about the problem that brings you here?

NO
 YES

If YES, please list these doctors' names and practice locations)

Name _____ Location _____

Name _____ Location _____

Name _____ Location _____

WHY HAVE YOU COME TO SEE US?

Please list the reason(s), symptom(s), or problem(s) that have led to your coming here. List the most important reason as #1.

- 1. _____
- 2. _____
- 3. _____

SMOKING HISTORY

Have you ever smoked cigarettes, cigars, or pipes?

NO *If NO, please skip to "Work History"*
 YES *If YES, at what age did you first start smoking? _____*

Are you still smoking?

NO *If NO, at what age did you quit? _____*
 YES

How many packs of cigarettes ON AVERAGE do (or did) you smoke each day? *(Please circle the number closest to your average)*

1 1 ½ 2 2 ½ 3 3 ½ 4

WORK HISTORY

Have you ever been employed outside of the home?

- NO *If NO, please skip to “Respiratory System Review”*
- YES

Are you still working?

- NO *If NO, when did you last work? _____*
- YES *If YES, what type of work have you done most recently?*

In what year did you first do this work? _____

Have you ever worked in any of the following: *(Please check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Farming | <input type="checkbox"/> Plumbing |
| <input type="checkbox"/> Foundry | <input type="checkbox"/> Popcorn Manufacturing |
| <input type="checkbox"/> Metal Working | <input type="checkbox"/> Stone Quarry |
| <input type="checkbox"/> Mines | <input type="checkbox"/> Welding |

Have you ever worked with or been exposed to the following: *(Please check all that apply)*

- Asbestos
- Beryllium
- Moldy Wheat or Wheat Dust

RESPIRATORY SYSTEM REVIEW

Shortness of Breath

Do you get short of breath when you walk or exert yourself?

- NO
- YES *If YES, please check the lowest level of exertion required to bring on a sensation of uncomfortable breathing:*

- No activity required (short of breath at rest)
- Very little exertion (getting dressed)
- Little exertion (walking room to room)
- Moderate exertion (making a bed or walking a block)
- Moderately heavy exertion (climbing two flights of stairs)
- Heavy exertion (walking fast up a long hill)

Shortness of Breath during Sleep or Lying Down

Do you awaken from sleep during the night because of shortness of breath?

- NO
- YES *If YES, how frequently does this happen? _____*






What seems to relieve your breathing after awakening with shortness of breath?

- Using my inhaled medications
- Sitting or standing up
- Letting time pass
- Other: _____

Do you get short of breath if you lie down flat?

- NO
- YES

If YES, at what angle do you have to sleep to be comfortable?

- 15° 
- 30° 
- 45° 
- 60° 
- 90° 

Sensitivity to Inhaled Materials

Is there anything that you have been around or inhaled that seems to make you wheeze, cough, or get short of breath?

- NO
- YES

If YES, please check all items that bother you:

- | | |
|---|--|
| <input type="checkbox"/> Aerosol sprays | <input type="checkbox"/> Dogs |
| <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> Cats |
| <input type="checkbox"/> Colognes, perfumes | <input type="checkbox"/> Trees |
| <input type="checkbox"/> Solvents | <input type="checkbox"/> Grass |
| <input type="checkbox"/> Cleaning compounds | <input type="checkbox"/> Ragweed |
| <input type="checkbox"/> Cold, dry air | <input type="checkbox"/> House dust |
| <input type="checkbox"/> Hot, humid air | <input type="checkbox"/> Molds or mildew |

Cough

Do you have some type of cough most days?

- NO *If NO, please skip to "Additional History"*
- YES

Do you cough up any mucus, phlegm, or sputum?

- NO *If NO, please skip to "Additional History"*
- YES

What color is the sputum most often?

- Clear, white, or foamy
- Green
- Yellow
- Other: _____

Approximately how much sputum do you usually cough up in the course of a 24-hour day?
(This is difficult to estimate, just give your best guess)

- | | |
|--|--|
| <input type="checkbox"/> 1 Teaspoon (5cc.s) | <input type="checkbox"/> ¼ Cup (60cc.s) |
| <input type="checkbox"/> 1 Tablespoon (15cc.s) | <input type="checkbox"/> ½ Cup (120cc.s) |
| <input type="checkbox"/> 1 Ounce (30cc.s) | <input type="checkbox"/> 1 Cup (240cc.s) or more |

Additional History

Have you ever coughed up any blood?

- NO
- YES

Have you ever been exposed to tuberculosis?

- NO
- UNCERTAIN
- YES *If YES, when? _____*

Have you ever had a skin test for tuberculosis?

- NO
- YES

If YES, when was your most recent skin test? _____

Have any of the skin tests been positive?

- NO
- YES *If YES, when? _____*

Are you bothered by pain in your chest?

- NO
- YES

Are you often bothered by a 'runny' or 'stuffy' nose?

- NO
- YES

If YES, do your symptoms vary from one season to another?

- NO
- YES *If YES, which seasons seem to be your worst? _____*

Do you think you have 'postnasal drip'?

- NO
- YES

Do you have problems with heartburn?

- NO
- YES

Do you ever awaken at night with 'sour brash' (acid, bitter-tasting stomach contents) in your throat or mouth?

- NO
- YES

MEDICATION ALLERGIES AND SENSITIVITIES

Has aspirin ever seemed to bother your breathing?

- NO
- YES
- UNCERTAIN

Have you had problems with reactions to other medications?

- NO *If NO, please skip to "Past Medical History"*
- YES *If YES, please list any medications that have bothered you as well as the reaction you have had to that drug (rash, trouble breathing, nausea, etc)*

DRUG	REACTION	DRUG	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITALIZATION

DATE

Other Medical Problems

Have you ever been diagnosed with one of the following:
(Please check all that apply and include the date when problem was first noted)

- Cancer _____
- High Blood Pressure _____
- Diabetes _____
- Liver Disease _____
- Heart Disease _____
- Thyroid Disease _____

If you have had other serious medical problems that are not mentioned elsewhere, please list below with the date the problem was first noted:

Immunizations

Have you ever had a pneumonia shot (pneumococcal vaccine)?

- NO
- UNCERTAIN
- YES In what year? _____

Have you had a flu shot (influenza vaccine) within the last 9 months?

- NO
- UNCERTAIN
- YES

SOCIAL LIFE / HABITS

Current Marital Status:

- Never Married
- Divorced
- Married Now
- Widowed

Do you live alone?

- NO
- YES

Have you traveled outside of the state of Indiana within the last year?

- NO
- YES

Do you ever drink alcoholic beverages?

- NO
- YES

If YES, how many ounces (or shots, cans, glasses) and how frequently (per day, week, month, or year)? _____

Are you currently using any intravenous 'recreational drugs' like cocaine, marijuana, etc?

- NO
- YES

Do you have any pets?

- NO
- YES

If YES, please check all that apply:

- Birds (including pigeons)
- Cats
- Dogs
- Other: _____

List all of your hobbies that may expose you to fumes or dust:
(this includes painting, woodworking, ceramics, etc)

FAMILY HISTORY

Please check all of the following conditions that any of your close blood relatives have experienced:

- Asthma
- Allergies/Hay Fever
- Auto-immune diseases (lupus, rheumatoid arthritis, etc)
- Diabetes
- Cystic Fibrosis

GENERAL SYSTEMS REVIEW

Are you currently having problems with any of the following? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Weight change of more than 5 lbs. over the last 6 months | <input type="checkbox"/> Irregular or too fast heartbeat |
| <input type="checkbox"/> Fever, shaking chills, sweats | <input type="checkbox"/> Numbness or weakness |
| <input type="checkbox"/> Easy fatigue, lack of energy | <input type="checkbox"/> Abdominal pain, nausea, vomiting, bowel problems |
| <input type="checkbox"/> Eyes (blurriness, double vision, etc) | <input type="checkbox"/> Bladder or kidney problems |
| <input type="checkbox"/> Ears or hearing | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Dental abscesses or periodontal disease | <input type="checkbox"/> Depression or anxiety |
| <input type="checkbox"/> Swallowing | <input type="checkbox"/> Bleeding which does not stop normally |

The doctor will be asking you additional questions about your presenting symptoms or problems as well as some of the other problems you've indicated on this form. If there is anything else, not addressed above, that you would like the doctor to know about yourself or your general medical history, please mention the issue(s) during your office visit and be prepared to discuss them.

THANK YOU FOR COMPLETING THE HISTORY QUESTIONNAIRE!