Initial Patient Questionnaire

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Reason for your visit today: Check off or briefly describe the reason for your visit today.

_____

_____

☐ Cough ☐ Asthma ☐ Abnormal X-ray/CT finding ☐ Medical Clearance ☐ COPD
☐ Dyspnea/shortness of breath ☐ Low oxygen level ☐ Bronchitis ☐ Pneumonia

How long have you had this problem?

_____

☐ Less than 1 month ☐ 2-3 months ☐ Greater than 3-6 months ☐ Greater than 1 yr
☐ Not applicable

What has helped the problem?

_____

☐ Not applicable

What makes the problem worse?

_____

☐ Not applicable

When do you most notice the problem?

_____

☐Not applicable

Past Medical History: Please check off any medical problems you have.

☐ Asthma ☐ COPD/Emphysema ☐ Sleep Apnea ☐ Seasonal allergies ☐ Stroke
☐Hypertension ☐ High Cholesterol ☐ Heart failure ☐ Heart Attack ☐ Osteoarthritis
☐Rheumatoid arthritis ☐ Sinus Problems ☐ Anemia ☐ GI bleed ☐ Crohn's Disease ☐Colitis
☐ DVT/PE ☐ Diabetes ☐ Kidney disease ☐ Thyroid problems ☐ Cancer☐ GERD/Reflux
☐ Liver disease/Hepatitis ☐ Connective Tissue Disease
Other: _____

Medications (Name, Strength, Frequency): Please include over-the-counter medications

☐ None

Name	Strength	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medication Allergies (with reaction): _____

_____

☐ No Known Drug Allergies

Hospitalizations: Please list the date, facility and reason for all prior hospitalizations

☐ None Most recent hospitalizations first

Date	Facility	Reason for Hospitalization
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Past Surgical History: Please list date, facility and type of surgery

☐ None Most recent first

Date	Facility	Type of Surgery
1.		
2.		
3.		
4.		
5.		

Do you have any of the following problems with sleep? Check all that apply.

☐ None/ Not applicable

☐ Snoring ☐ Gasping awakenings ☐ Morning headache
☐ Daytime fatigue ☐ Unintentional falling asleep ☐ Poor quality sleep
☐ Other_____

Please check off if you have any of the following problems/symptoms.

Respiratory/Lung: ☐ None
☐ Cough ☐ Sleep disturbance with breathing ☐ Snoring ☐ Shortness of breath
☐ Sputum production ☐ Coughing up blood ☐ Wheezing
☐ Other: _____

General/Constitutional: ☐ None
☐ Fever ☐ Chills ☐Sweats ☐ Appetite loss ☐ Fatigue ☐ Malaise ☐ Weight loss
☐ Weight gain
☐ Other: _____

Vision/Ear/Nose/Throat: ☐ None
☐ Vision problems ☐ Eye pain ☐ Light sensitivity ☐ Nasal congestion ☐ Earache
☐ Nosebleed ☐ Sore throat ☐ Difficulty swallowing ☐ Postnasal drip
☐ Other: _____

Cardiac/Heart: ☐ None
☐ Chest pain/pressure ☐ Racing/skipping heart beats ☐ Lightheadedness
☐ Palpitations ☐ Shortness of breath with exertion ☐ Swelling of hands or feet
☐ Difficulty breathing when lying down
☐ Other: _____

Gastrointestinal/Urinary: ☐ None
☐ Indigestion ☐ Heart Burn ☐ Nausea ☐Vomiting ☐ Abdominal pain ☐Bloating
☐ Diarrhea ☐ Constipation ☐ Urinary Frequency ☐ Urinary urgency
☐ Problems starting urinary stream
☐ Other: _____

Musculoskeletal/Skin: ☐ None
☐ Joint pain ☐ Joint swelling ☐ Back pain ☐ Gout ☐ Arthritis ☐ Muscle aches
☐ Muscle weakness ☐ Skin lesions ☐ Itching ☐ Rash ☐ Skin discoloration
☐ Other: _____

Neurological: ☐ None
☐ Headaches ☐ Poor Balance ☐ Memory Problems ☐ Numbness ☐ Seizure
☐ Fainting ☐ Tingling ☐ Dizziness
☐ Other: _____

Psychiatric: ☐ None
☐ Depression ☐ Anxiety ☐ Racing thoughts ☐ Heat intolerance ☐ Cold Intolerance
☐ Excessive hunger ☐ Excessive thirst ☐ Unintentional weight changes
☐ Other: _____

Allergic/Blood Related: ☐ None
☐ Easy bruising ☐ Easy bleeding ☐ Enlarged lymph nodes
☐ Seasonal Allergies ☐ Hives ☐ Recurrent infections
☐ Other: _____

Occupational History- What types of jobs have you? What industries have you worked in?

Exposure History- Have you been exposed to any of the following? Check all that apply.
☐ No known exposures
☐ No animal exposures

☐ Asbestos ☐ Radon ☐ Coal dust ☐ Animals - which: _____
☐ Birds ☐ Mold ☐ Ponds/pools ☐ Evaporative cooler ☐ Humidifier ☐ Hot tub ☐ Silica
☐ Second hand smoke ☐ Tuberculosis

Are there any animals in the home, and what type?

_____

Please list any travel: (Over the past five years within the US, or any travel internationally)

1.
2.
3.
4.
5.

Tobacco history: Do you smoke?
☐ Current ☐ Former ☐ Never
At what age did you start smoking? _____
At what age did you quit smoking? _____
How much did/do you smoke (on average)? _____ Packs per day

Do you drink alcohol?
☐ Yes ☐ No
☐ Beer ☐ Wine ☐ Cocktail
How many drinks per week? _____

Do you use any other inhaled substances (Marijuana)? ☐ Other: _____
☐ Yes ☐ No
How many times per week? _____

Are your parents living?
Father: ☐ Yes ☐ No
Mother: ☐ Yes ☐ No

Family History: Please list any medical problems regarding your:

Mother: ☐ None _____

Father: ☐ None _____

Siblings: ☐ None _____ # of Siblings _____

Children: ☐ None_____# of children_____

If you have Asthma:
How many times per week do you use your rescue inhaler? _____
How many nights per week do you have Asthma symptoms? _____

Vaccine Information:
Flu Vaccine Date:_____

COVID Vaccine (circle): Yes | No

Pneumonia Vaccine Date:_____