



Pulmonary Associates of St. Augustine

PATIENT'S NAME: _____ SEX: M/F AGE: _____ DATE _____
REFERRED BY: _____ YOUR PRIMARY PHYSICIAN: _____
BRIEFLY DESCRIBE REASON FOR YOUR VISIT _____

RESPIRATORY SYMPTOMS: (CIRCLE **ALL** THAT APPLY)

Do you have any of the following complaints?

1. Shortness of Breath: Y/N, how long? _____
2. Are you short of breath resting? Y/N
3. How much can you walk before getting short of breath? Block? _____ Room to Room? _____
4. What triggers your shortness of breath? trees Y/N cats Y/N birds Y/N activity Y/N wind Y/N heat Y/N humidity Y/N cold air Y/N pollen Y/N ragweed Y/N other _____
5. Any breathing problems as a child, teenager, or adult? _____
6. Have you ever taken any medications (tablets or inhalers) for breathing problems? If yes, please list: _____
7. Do you have a home nebulizer? Y/N
8. Are you on Home oxygen? Y/N, how long? _____
9. How many pillows do you use under your head when sleeping? _____
10. Do you wake up at night short of breath? Y/N or choking? Y/N
11. Do you have swelling in your feet or ankles? Y/N
12. Cough? Y/N, how long? _____ Dry/Productive, color of phlegm (sputum) _____
13. Have you ever coughed up blood or streaks of blood? Y/N, when? _____
14. Have you ever had: Wheezing? Y/N Chest Pains? Y/N Heartburn? Y/N Choking on food? Y/N Runny Nose? Y/N Post Nasal Drip? Y/N Frequent throat clearing? Y/N Nosebleeds? Y/N Weight Loss? Y/N Weight Gain? Y/N Skin Rash? _____

SLEEP HISTORY: (CIRCLE **ALL** THAT APPLY)

Sleep Apnea? Y/N Restless leg syndrome? Y/N Snoring? Y/N Daytime Sleepiness? Y/N
Daytime Fatigue/Tiredness? Y/N

PAST MEDICAL HISTORY: (CIRCLE **ALL** THAT APPLY)

Have you ever been diagnosed with:

1. Asthma? Y/N, how long? _____
2. COPD? Y/N, how long? _____
3. Emphysema? Y/N, how long? _____
4. Chronic Bronchitis? Y/N Bronchiectasis? Y/N
5. Blood clots (phlebitis) in legs? Y/N
6. Cystic Fibrosis? Y/N
7. Pneumonia? Y/N, when? _____ Did it require hospitalization? Y/N
8. Tuberculosis (TB)? Y/N, when? _____ Did you ever have a positive TB skin test? Y/N
9. Do you have high blood pressure? Y/N Diabetes Mellitus Y/N Stomach Ulcer? Y/N
10. Lung Cancer? Y/N, what treatment was given? Chemo? Y/N, when? _____
Radiation? Y/N, when? _____ Surgery? Y/N, when? _____
11. Any other cancers? Y/N, explain _____
12. Heart Attack? Y/N Congestive Heart Failure? Y/N

PAST SURGICAL HISTORY: (CIRCLE **ALL** THAT APPLY)

1. Chest or lung surgery? Y/N, what kind? _____ When? _____
2. Tonsils removed? Y/N
3. Sinus surgery? Y/N
4. Uterus and/or ovaries removed? Y/N
5. Gall Bladder Removed? Y/N
6. Appendectomy? Y/N
7. Any other surgeries? Y/N, what? _____ when? _____

FAMILY HISTORY: (In true blood relation) (CIRCLE **ALL** THAT APPLY)

(Problems: Asthma, COPD, Emphysema, Cystic Fibrosis, End-stage Cancer, D.V.T., P.E., Sleep Apnea)

Mother: Problem _____ Living/Deceased

Father: Problem _____ Living/Deceased

True Brother and Sister: Problem _____

Children: Y/N, Problem _____

VACCINATION HISTORY: (CIRCLE **ALL** THAT APPLY)

FLU SHOT: Y/N, when? _____

Pneumonia Vaccine (shot) Y/N, when? _____

OCCUPATIONAL HISTORY: (CIRCLE **ALL** THAT APPLY)

1. What work have you done most of your life? _____

2. Have you had exposure to any of the following?

A. Asbestos (car brakes, pipe fitter, roofing, tiling, boiler work, ship yard work)

B. Sand/ Silica dust, cement (construction work)

C. Smoke inhalation (Firefighter)

D. Heavy metal grinding/tool and dye making.

E. Farm work

F. Mustard gas, nerve gas, agent orange, lewisite, military experiments.

G. Desert Storm

H. Veterinarian work

SOCIAL HISTORY: (CIRCLE **ALL** THAT APPLY)

Have you ever smoked cigarettes, cigar, or a pipe? Y/N Do you currently smoke cigarettes? Y/N

If yes, estimate the average packs of cigarettes per day while you were smoking: _____

Years of cigarette smoking: _____ If you quit smoking, when did you quit? _____

Please indicate the number of cups per day consumed of caffeinated beverages: _____

Do you currently smoke marijuana or take any other mood-altering illicit drugs? Y/N

If yes, what and how often: _____

Did you ever drink alcohol? Y/N Do you currently drink alcohol? Y/N Amount? _____

ENVIRONMENTAL HISTORY: (CIRCLE **ALL** THAT APPLY)

Do you have any of the following?

A. Pets? (Example): Cats Y/N Dogs Y/N Birds Y/N Other _____

B. Home air conditioning? Y/N Home air cleaner/ Hepa filter? Y/N

C. Dusty environment at home? Y/N

TRAVEL HISTORY: (CIRCLE **ALL** THAT APPLY)

A. Travel to southwest or Midwest? Y/N When? _____

B. Travel to far east countries? Y/N When? _____

C. Travel to South America/ Haiti? Y/N When? _____

ALLERGIES: (PLEASE LIST ALL ALLERGIES)

Food Allergy: _____ Egg Allergy: Y/N Peanut Allergy: Y/N

Medication Allergy: _____

Environmental Allergy: _____

Have you ever seen an allergy specialist? Y/N Had allergy testing? Y/N Allergy shots? Y/N When? _____