Montgomery County Pulmonary and Sleep Consultants, PC

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PULMONARY PATIENT QUESTIONAIRE

(Please complete prior to your office visit)

Name _____ DOB _____ Age _____ Sex: CIRCLE M F

Primary Care / Referring Doctor _____

MEDICAL HISTORY

(Please check all conditions identified in you or your immediate family members)

Condition	Self	Family	Condition	Self	Family
Migraine Headaches	☐	☐	High Blood Pressure	☐	☐
Seizures or Convulsions	☐	☐	Stomach Ulcer	☐	☐
Stroke	☐	☐	Liver Disease	☐	☐
Glaucoma	☐	☐	Colon or Bowel Trouble	☐	☐
Allergies	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Arthritis	☐	☐
Emphysema	☐	☐	Gout	☐	☐
Tuberculosis	☐	☐	Thyroid Problems	☐	☐
Heart Trouble	☐	☐	Mental Illness	☐	☐
Bleeding Problems	☐	☐	Suicide or Attempted Suicide	☐	☐
Anemia	☐	☐	Birth Defects	☐	☐
Sickle Cell Disease	☐	☐	Cystic Fibrosis	☐	☐
Cancer, include Leukemia	☐	☐	Pulmonary Fibrosis	☐	☐
Diabetes	☐	☐	Sleep Apnea	☐	☐

SOCIAL / PERSONAL HISTORY

(Please complete the following information about yourself)

Current Occupation _____ Previous Occupation _____

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Partnered

Personal Habits (Check all that apply)

❑ Current tobacco use: ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Smokeless Tobacco ____ packs/day ____ years
❑ Former Smoker: Amount / Day ____ Years ____ Quit Date _____
❑ Exposed to second-hand smoke: ❑ Asbestos ❑ Chemical Fumes ❑ Coal Dust ❑ Birds
❑ Dogs ❑ Cats ❑ Other animals - Types _____
❑ Consume Alcohol: Type _____ Amount / day _____
❑ Consume caffeine: Beverage _____ Amount / day _____
❑ Exercise regularly: Type _____ Frequency / week _____
❑ Recreational drug use: _____

NAME _____ **AGE** _____ **DOB** _____

Why are you here to see a pulmonary (lung) doctor? _____

_____

_____

_____

Check off any lung or breathing problems or symptoms

- ☐ Unable to catch your breath
- ☐ Wheezing
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Unable to sleep laying flat or with one (1) pillow
- ☐ Night Sweats
- ☐ Coughed up blood
- ☐ Chest pains or pressure
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Swollen legs
- ☐ Heart failure
- ☐ Blue lips or fingernails
- ☐ Leg cramps when you walk

Have you ever had:

- ☐ A pulmonary function test or spirometry
- ☐ A pulmonary stress test
- ☐ A bronchoscopy or bronchial/lung biopsy
- ☐ Lung surgery, including removal of a lobe
- ☐ An electrocardiogram
- ☐ Heart surgery
- ☐ Lung cancer
- ☐ Exposure to tuberculosis or had tuberculosis
- ☐ Pneumonia
- ☐ Blood clot

Are you being treated now or have been treated for any illness?

(Please list them)

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