Pulmonary, Critical Care and Sleep Medicine Specialists of SW FL

NEW PATIENT QUESTIONNAIRE

Patient Name_____ **DOB** _____ **Age**:_____

What is the reason for today's appointment?_____

PULMONARY ISSUES: Please tell us if you have a history of any of the following [place a check if YES]:

Asthma _____ COPD _____ Bronchiectasis _____ Pneumonia _____

Recurrent bronchitis _____ Abnormal CXR/spot on lung _____ Lung Cancer_____

Pulmonary Embolus (blood clot in lung) _____ DVT(blood clot in leg)_____ TB_____

Pulmonary Hypertension _____ Pulmonary Fibrosis _____

Please tell us if you have recently had any of the following [place a check if YES]:

Cough_____ Wheezing_____ Shortness of breath_____ Sputum/mucus_____

Coughing up blood _____ Night time respiratory symptoms_____ Chest tightness_____

DME INFORMATION – OXYGEN and/or CPAP:

Do you use a CPAP? _____ Yes _____ No

Do you use Oxygen equipment? _____ Yes _____ No Do you have a concentrator? _____ Yes _____ No

Do you use portable O2? _____ Yes _____ No What is your O2 Setting? _____lpm

When do you wear your O2? (circle) Always Nighttime With Exertion Only as needed

Name of Oxygen and/or CPAP Company? _____

MEDICATIONS: Please present Medical Assistant with a list of your medications to be reviewed.

Do you need **REFILLS** on your medications? If yes, which ones:_____

Do you prefer **3 month** prescriptions? Yes _____ No _____

Do you use a mail away pharmacy for long term medications? Yes _____ No _____

Mail Away Pharmacy Name _____

Are you allergic to any of the following: (circle all that apply)

Dogs Cats Trees Grasses Pollen Mold Dust

Have you recently been exposed to any of the following? (circle all that apply)

Birds Cats Dogs Mold damage in home Wood Dust Hot Tubs

FAMILY HISTORY:

Does anyone in your family have a history of: _____COPD _____ Asthma _____Lung cancer _____Sleep Apnea
_____Pulmonary Fibrosis _____Blood Clots in legs/lungs (DVT, pulmonary emboli)

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Past Medical History: **Past Surgical History:**

Medical Diagnosis:	Year diagnosed	Surgery:	Year
Allergies		Nasal/sinus surgery	
Sinus Infections		Eye surgery	
GERD/ acid reflux		Tonsils, UPPP	
Ulcers or bleeding from GI tract		Lung surgery	
Heart attack /MI/angina		Heart surgery	
CHF/congestive heart failure		Gallbladder surgery	
HTN		Surgery on bowels	
Heart arrhythmias (such as A-Fib)		Weight loss surgery	
Stroke/TIA		Back, neck, spine surgery	
Diabetes Mellitus		Knee replacement	
Thyroid disease		Hip replacement	
Kidney disease		Kidney, bladder surgeries	
Cancer			
Anemia, bleeding disorders			
Scleroderma, Rheumatoid Arthritis			

PLEASE LIST ANY MEDICAL CONDITIONS OR SURGICAL PROCEDURES YOU HAVE HAD THAT ARE NOT LISTED ABOVE:

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? Yes _____ No _____ If yes, how many per week? _____

Do you live in Florida year round? Yes _____ No _____

Are you still working? Yes _____ No _____ What is/was your occupation? _____

Did you ever work with asbestos or other substances that can hurt the lungs? Yes _____ No _____

Do you have a LIVING WILL? Yes _____ No _____

REVIEW OF SYSTEMS [*Please CIRCLE if you have any of these problems/symptoms*]:

Constitutional: night sweats loss of appetite weight loss
Infectious Disease fever chills
Nose/sinuses: runny nose post nasal drip sinus congestion sinus pain
THROAT: sore throat hoarse voice difficulty swallowing sore throat thrush/yeast
CARDIAC: chest pain palpitations swelling of feet or legs trouble breathing when you lie flat
GASTROINTESTINAL: nausea vomiting abdominal pain GERD/heartburn cough with eating
blood in bowel movements black stool
GENITOURINARY: frequent urination at night blood in urine
MUSCULOSKELETAL: stiff or painful joints neck pain back pain
NEUROLOGIC: headaches dizziness tremors weakness of arms or legs
PSYCHIATRIC: anxiety depression
SKIN: rash itching fingers turn colors if exposed to cold
OTHER:: _____

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SLEEP:

Have you ever been diagnosed with a sleep condition? Yes _____ No _____

Have you ever had a sleep study? Yes _____ No ____ Where/when? _____

What time do you go to bed? _____ Do you fall asleep easily? Yes _____ No _____

How long does it take you to fall asleep?_____ Do you take sleeping pills? Yes _____ No _____

Do you drink alcohol after dinner? Yes _____ No _____ How many times do you wake up during the night? _____

What time do you wake up in the morning?_____ Do you use an alarm clock? Yes _____ No _____

Do you use the snooze button? Yes _____ No _____ Do you have morning headaches? Yes _____ No _____

Do you take naps? Yes _____ No _____ Do you snore? Yes _____ No _____

Do you stop breathing during sleep? Yes _____ No _____ What position do you sleep in? _____

Do you get leg cramps at night? Yes _____ No _____ Do your legs move during sleep? Yes _____ No _____

Do you get "weak in the legs" when you feel a strong emotion (hear something funny or sad)? Yes _____ No _____

Do you ever feel paralyzed [can't move] when falling asleep or waking up? Yes _____ No _____

Do you have hallucinations (visual or auditory-hearing things) when falling asleep/waking up? Yes _____ No _____

CPAP or BiPAP:

Are you having problems with your device? Yes _____ No _____

On average, how many hours do you use your CPAP/BIPAP? _____hrs

What type of mask do you have? Nasal Mask Full Face Mask Nasal Pillows

EPWORTH SCALE:

In the past month, how likely are you to doze off [that means your eyes close and your head droops] OR fall asleep in these situations?

0= never 1= slight chance 2 = medium chance 3= high chance

ACTIVITY	SCORE
Sitting and resting	
Watching TV-	
Sitting inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon, would you fall asleep?	
Sitting and talking with someone-	
Sitting quietly after lunch	
In a car stopped for a few minutes	
TOTAL	

_____ _____

Patient or Authorized Representative Signature Date of completion

_____ _____

Physician Signature Date