



# Pulmonary Medicine Associates

**New Patient Self-Questionnaire**

The purpose of this self-history is to give your physician as complete a record as possible of your past health experience. By reducing the amount of time the physician has to spend writing down details, the self-history form will provide a better health interview between you and the physician. The form should be filled in as completely as possible. Information you may think is unimportant may actually be of real value to the physician in diagnosing and following your illness.

**ALL INFORMATION GIVEN IS CONFIDENTIAL**

---

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex..... Male  Female

1. What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When did the symptom(s) first start? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please ✓ if you have any of the following problems:

**Cough**

- Cough first thing in the morning
- Cough at other times during the day
- Cough on most days  
How long have you had this cough? \_\_\_\_months \_\_\_\_years
- Bring up phlegm (mucus, sputum) in the morning
- Bring up phlegm at others times of the day  
How long have you produced phlegm? \_\_\_\_months \_\_\_\_years  
What is the usual color of your phlegm? \_\_\_\_\_

**Hemoptysis (coughing up blood)**

- Coughed up blood from your chest  
If yes, when, how many times and approximately how much?  
\_\_\_\_\_  
\_\_\_\_\_

**Wheezing or chest tightness**

- Wheezing ..... few times a week  few times month  few times year
- Chest tightness..... few times a week  few times month  few times year

Are there any triggers that bring on your wheezing or chest tightness (i.e., exposure to dust, tobacco smoke, plants or pollen, contact with animals or with exercise? (Please list below.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Breathlessness or Shortness of breath**

- Experience shortness of breath
- Experience shortness of breath at rest
- Have to stop when walking or walk at slow pace

How far can you walk before becoming short of breath or need to rest?

\_\_\_\_\_  
\_\_\_\_\_

What causes you to become short of breath? (Please list below)

\_\_\_\_\_  
\_\_\_\_\_

4. Any Allergies? Please list below and type of reaction for each:

Medicine \_\_\_\_\_

Food \_\_\_\_\_

Dander \_\_\_\_\_

Pollen \_\_\_\_\_

Other \_\_\_\_\_

5. Do you take any medications on a regular basis? Please list name and dose:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Have you ever used alcoholic beverages? ..... Yes  No

If yes, please check below current usage:

- None for \_\_\_\_\_ years       Daily  
 Socially only                       To excess on occasion

### Smoking History

7. Did you ever smoke cigarettes? ..... Yes  No If yes, how long? \_\_\_\_\_yrs

Do you still smoke? ..... Yes  No

If you quit smoking, how many years did you smoke and when did you quit?

\_\_\_\_\_

What was the average amount of cigarettes you smoked per day?

- less than ½ pack     ½ pack     1 pack     2 packs     >2 packs

### Past Medical History

8. Have you ever been told that you have any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Asbestosis                    | <input type="checkbox"/> Lung disease (occupational) |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Lupus                       |
| <input type="checkbox"/> Chronic bronchitis            | <input type="checkbox"/> Pleurisy                    |
| <input type="checkbox"/> Diabetes Mellitus             | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Pulmonary Fibrosis          |
| <input type="checkbox"/> Heart Attack                  | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input type="checkbox"/> Heart Rhythm Problems         | <input type="checkbox"/> Sarcoidosis                 |
| <input type="checkbox"/> Hypertension                  | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Interstitial Lung Disease     | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Lung collapse or pneumothorax |  |

Please list any chronic conditions not mentioned above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Disease History	Age	Complications
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Chickenpox	_____	_____
<input type="checkbox"/> Diphtheria	_____	_____
<input type="checkbox"/> Epilepsy	_____	_____
<input type="checkbox"/> German Measles	_____	_____
<input type="checkbox"/> Influenza	_____	_____
<input type="checkbox"/> Malaria	_____	_____
<input type="checkbox"/> Mumps	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____
<input type="checkbox"/> Rheumatic Fever	_____	_____
<input type="checkbox"/> Scarlet Fever	_____	_____
<input type="checkbox"/> Smallpox	_____	_____
<input type="checkbox"/> Tonsillitis	_____	_____
<input type="checkbox"/> Tuberculosis	_____	_____
<input type="checkbox"/> Typhoid Fever	_____	_____
<input type="checkbox"/> Venereal Disease	_____	_____
<input type="checkbox"/> Whooping Cough	_____	_____

**Surgical History**

Type of Surgery	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Prior Hospitalizations**

Reason for hospitalization	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Have you ever needed to be intubated or placed on a ventilator? ...  Yes  No

When and for how long? \_\_\_\_\_

**Preventative Care**

10. Last Flu shot \_\_\_\_\_ year      Pneumonia shot \_\_\_\_\_ year

TB skin test (year and result) \_\_\_\_\_

Allergy skin testing (year and result) \_\_\_\_\_

**Family History**

11. Please explain where appropriate

Family member	Living or deceased	Age or age at death	Illnesses or cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
Sister	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
Children	_____	_____	_____
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please list any diseases that are more common in your family than other families:

\_\_\_\_\_  
\_\_\_\_\_

**Occupational History**

12. Please list all previous occupations from your first job to your current job

Industry/Company	Location	Year	Your specific job
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Have you ever worked: (Please indicate how long)

- In a dusty job? \_\_\_\_\_
- In a mine? \_\_\_\_\_
- In a quarry? \_\_\_\_\_
- In a foundry? \_\_\_\_\_
- In a pottery? \_\_\_\_\_
- In a cotton, flax or hemp mill? \_\_\_\_\_
- In a brick plant? \_\_\_\_\_
- With asbestos? \_\_\_\_\_
- As a sandblaster? \_\_\_\_\_
- In the manufacture of glass, ceramics or abrasives? \_\_\_\_\_
- In other dusty jobs? Please specify: \_\_\_\_\_

14. Have you ever worked with chemicals? Please indicate specifics and how long:

- |   |   |
|---|---|
| <input type="checkbox"/> Acids _____    | <input type="checkbox"/> Nickel _____   |
| <input type="checkbox"/> Arsenic _____  | <input type="checkbox"/> Plastics _____ |
| <input type="checkbox"/> Cadmium _____  | <input type="checkbox"/> Solvents _____ |
| <input type="checkbox"/> Chromium _____ | <input type="checkbox"/> TDI _____      |
| <input type="checkbox"/> Lead _____     | <input type="checkbox"/> Uranium _____  |

**Residence**

15. Please list previous places you have lived and how long:

Year	Country or state in the United States
_____	_____
_____	_____
_____	_____

16. Please check if you have had any of these tests in the past 2 years: (Indicate date and facility)

- Blood chemistries \_\_\_\_\_
- Blood count \_\_\_\_\_
- Cardiac ultrasound \_\_\_\_\_
- Chest x-ray \_\_\_\_\_
- CT scan chest \_\_\_\_\_
- CT scan sinus \_\_\_\_\_
- Electrocardiogram \_\_\_\_\_
- Pulmonary function test (breathing test) \_\_\_\_\_
- Sleep study \_\_\_\_\_

## REVIEW OF SYSTEMS

Weight: Current \_\_\_\_\_ Usual \_\_\_\_\_

Has your weight changed in the last year?  Yes  No

Please check if you have any symptoms below (indicate last date of each symptom and any detail).

### **Cardiopulmonary**

- Chest pain
- Shortness of breath
- Cough
- Wheezing
- Unusual heart beat
- Swollen feet or legs
- Difficulty breathing when lying down, but gets better when sitting up

### **Ears**

- Difficulty hearing
- Earaches
- Discharge from ears
- Buzzing or ringing in ears

### **Eyes**

- Glasses
- Pain
- Drainage
- Decreased vision
- Seeing double
- Pain in eyes

### **Gastrointestinal**

- Frequent heartburn or indigestion
- Nausea or vomiting
- Belching
- Stomach pain
- Diarrhea
- Constipation
- Blood in stool

### **Genitourinary**

- Painful urination
- Frequent urination
- Bloody urine
- Discharge (penile or vaginal)

### **Mouth**

- Decayed teeth/toothaches
- Bleeding gums
- Loss of taste
- Sore on lips

### **Musculoskeletal**

- Painful joints
- Sore muscles
- Back pain

### **Neck**

- Enlarged mass in neck
- Tender glands
- Swollen glands
- Difficulty swallowing

### **Neuropsychiatric**

- Frequent or severe headaches
- Dizziness or faintness
- More nervous than average person

### **Nose and throat**

- Frequent sneezing
- Nose bleeds
- Nose continually stuffed or runny
- Recurrent sore throats; persistent hoarseness
- Loss of voice
- Heavy snoring
- Injury
- Loss of smell

### **Skin**

- Chronic or recurring skin condition
- Lump or growth on skin
- Change in color of skin

### **Sleep**

- Tired during the day/require naps
- Loud snoring
- Stop breathing during sleep or wake up gasping for air
- Insomnia
- Morning headaches

If you have checked above, please fill out a sleep questionnaire

### **For Women Only**

- Irregular periods
- Bleeding between periods

Date of last menstrual period \_\_\_\_\_