INFORMATION FOR YOUR PHYSICIAN

ADM. NO. _____

Please answer the following questions and bring this record to your first examination. It will help your physician to know not only about your health but also about your family and relatives.

Date _____

Clinic No. _____ Your full name _____ Telephone Number _____

Age _____ Place of Birth _____ Race or Nationality of Parents _____

Religion _____ Education _____ (Highest level attained) Age on Completion _____ Occupation _____ How Long? _____

Where and when have you lived or traveled outside the U.S. and Canada _____

	Living		Age or age at death	Present health or cause of death
Father	Yes	No	_____	_____
Mother	Yes	No	_____	_____
Spouse	Yes	No	_____	_____

Present Marriage – year _____ Previous Marriage – year and duration _____

Brothers No. Living _____ Health _____
No. Dead _____ Cause of death _____

Sisters No. Living _____ Health _____
No. Dead _____ Cause of death _____

Children Living _____ Ages and health _____

Children Dead _____ Ages and causes _____

Please circle illnesses which have occurred in any of your *blood relatives*

Diabetes	Cancer	Bleeding Tendency	Kidney Disease	Tuberculosis
Heart Disease	Stroke	High Blood Pressure	Nervous Illness	Allergy

Please circle illnesses or condition *you* have had

Diabetes	Glaucoma	Heart trouble	Syphilis	Vein trouble
Diabetes, insulin taking	Asthma	Jaundice	Gonorrhea	Bleeding tendencies
Cancer	Pneumonia	Kidney Disease	Rheumatic fever	Nervous disorder
Tuberculosis				

Please list other illnesses not requiring operation for which you were hospitalized _____

Have you had serious injuries, broken bones, etc? _____ List _____

Have you had allergies or sensitivity to medicines or other substances? _____ Please describe _____

Do you use tobacco now? _____ In the past? _____ Type and daily amount _____ How long? _____
Do you use alcoholic beverages? _____ Type? _____ Weekly amount _____ How long? _____
Please check the diseases against which you have been immunized

☐ Smallpox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Other _____

Previous operations Please list, giving dates, hospital where performed and name of surgeon _____

Previous x-ray therapy or similar treatment _____

Medications Please name or otherwise identify medicines now or recently used _____

Menstrual History Last period (Date onset) _____Periods are ☐ Regular ☐ Irregular Number of pregnancies____ Number of miscarriages ____
Have you taken Cortisone-type drugs? _____ Oral contraception? _____ Have you received a blood transfusion? _____ Date _____
Your weight dressed _____ How long have you been at this weight? _____

Please write the reason you came to the Pulmonary / Sleep Clinic at this time _____

What is your main medical problem now and how long have you had it? _____

What is your main symptom? (For example: pain in chest, shortness of breath) _____

Reviewed _____ Date _____
Physician

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

__ EMPHYSEMA
__ BRONCHITIS
__ ASTHMA
__ PULMONARY FIBROSIS
__ LOW OXYGEN LEVEL
__ BRONCHIECTASIS
__ CONNECTIVE TISSUE DISEASE
__ TUBERCULOSIS

2. Do you feel short of breath with..?

__ CLIMBING 5 FLIGHTS OF STAIRS
__ CLIMBING 3 FLIGHTS OF STAIRS
__ CLIMBING 1 FLIGHT OF STAIRS
__ LIGHT WORK
__ STRENUOUS WORK
__ WALKING ON LEVEL GROUND
__ GETTING DRESSED
__ SITTING AT REST

3. Do you have a family history of lung disease?

__ MOTHER TYPE_____
__ FATHER TYPE_____
__ UNCLE TYPE_____
__ AUNT TYPE_____
__ BROTHER TYPE_____
__ SISTER TYPE_____

4. Have you ever been told you had any of the following?

__ HEART ATTACK
__ HEART FAILURE
__ HEART MURMUR
__ CHEST PAIN
__ HEART DISEASE
__ HEART BLOCK
__ ANKLE SWELLING

5. Do you have diabetes?

__ YES
__ NO

If yes, how is it controlled:

__ DIET
__ MEDICATION
__ INSULIN
__ EXERCISE
__ OTHER

6. Do you have high blood pressure?

__ YES
__ NO

If yes, how is it controlled?

__ DIET
__ MEDICATION
__ EXERCISE
__ OTHER

7. Have you ever had a chest or lung surgery?

__ YES
__ NO

8. Do you smoke?

__ CIGARETTES/PACKS PER DAY _____
__ PIPE
__ CIGARS

9. Have you ever smoked?

__ YES
__ NO

If yes how many years? _____
WHEN DID YOU QUIT? _____

10. Do you usually have a cough?

__ YES
__ NO

11. Do you usually cough more..?

__ IN THE MORNING
__ IN THE AFTERNOON
__ IN THE EVENING
__ ALL DAY

12. Do you usually cough up mucous?

__ YES
__ NO

13. If you measured your mucous for a day, how much might
there be?
__ A TEASPOON
__ A TABLESPOON
__ ¼ CUP
__ ½ CUP
__ MORE

14. What color do you usually see?

__ CLEAR
__ WHITE
__ YELLOW
__ BROWN
__ GREEN
__ BLOODY

15. Do you bring up mucous on most days for as much as
3 months a year?

__ YES
__ NO

16. Do you hear yourself wheeze when you breathe?

__ YES
__ NO

17. How often do you notice wheezing?

__ WEEKLY
__ MONTHLY
__ DAILY
__ NOT OFTEN

18. Do you have a cold all winter?

__ YES
__ NO

19. Do you have more shortness of breath when the weather changes?

__ YES
__ NO

20. Do you have sinus drainage or hay fever?

__ YES
__ NO

21. Do you have heartburn, gas, belching or hiatal hernia?

__ YES
__ NO

22. Do you wake up at night?

__ YES
__ NO

If so, for what reason? _____

23. Do you have more shortness of breath when lying down?

__YES
__ NO

24. How many pillows do you sleep on? _____

25. When was your last chest x-ray taken? _____
Was it normal? _____

26. What medications do you take?

_____
_____
_____
_____
__ NONE

27. Are you sensitive to any of the following?

__ AEROSOL SPRAYS
__ ANIMALS
__ DUST
__ PERFUMES
__ PLANTS
__ POLLENS
__ FUMES

28. Do you get short of breath when you get nervous?

__YES
__ NO

29. Have you ever had a job that exposed you to a large amount
of...?

__ DUST
__ SMOKE
__ FUMES

What type of job? _____

30. Have you ever worked as a?

__ WELDER
__ SANDBLASTER
__ COAL MINER
__ ASBESTOS
__ POTTERY
__ CARPENTER/WOODWORK

31. Do you presently use oxygen?
__ YES
__ NO

IF NO, GO TO QUESTION #35

32. When do you use your oxygen?

__ ALL THE TIME
__ WHILE SLEEPING
__ SOMETIMES
__ WHEN I THINK I NEED IT
__ WITH EXERCISE
__ OTHER _____

33. What type of oxygen do you use?

__ CONCENTRATOR
__ LIQUID
__ TANKS

34. How many liter do you use?

__ LITERS ALL THE TIME
__ LITERS WITH EXERCISE
__ LITERS AT REST
__ LITERS WITH SLEEP

35. If you are not using now, have you used it in the past?

__ YES
__ NO

36. Please check any of the following you feel cause you shortness of breath.

__ SITTING
__ GETTING DRESSED
__ TAKING A SHOWER
__ WALKING ON A FLAT SURFACE
__ WALKING UP A HILL
__ SLEEPING
__ EATING
__ LIGHT WORK
__ HEAVY WORK
__ STRESS
__ CHANGES IN WEATHER
__ INTERCOURSE
__ OTHER

37. Do you have any hobbies?

__ YES
__ NO

What kind of hobbies?

_____
_____

38. Have you given up any hobbies?

__ YES
__ NO

39. Do you own any pets?

__ YES
__ NO

If so, what kind?

_____
_____

40. Are you aware of tuberculosis exposure? If so, when?

_____
_____

41. Have you had a tuberculosis skin test?

__ YES
__ NO

If so, when? _____

Positive _____ Negative _____

42. Do you have a history of second hand smoke inhalation?

__ YES
__ NO