Department of Pulmonology

Dr. _____

Date of Appt _____

Time _____

Dear Patient:

Please complete the enclosed questionnaire and bring it with you to the clinic on the day of your appointment.

The proper insurance authorization, and your medical history, including current medical records, and x-rays related to this visit are also necessary for your evaluation.

If you have any questions, please feel free to contact me at 813.974.2553

Thank you,

Janice McCaskill, CPFT

PULMONARY DISEASE
UNIVERSITY OF SOUTH FLORIDA MEDICAL CENTER

Name _____ Address _____

Phone No. _____ Age _____ Sex_____

Race _____ Social Security No. _____ Height ____ Weight ____ lb.

Past Medical History

Have you ever had or been told that you had any of the following?
If YES, please check:

Childhood Illnesses

- ☐ Rheumatic fever
- ☐ Measles
- ☐ Asthma
- ☐ Scarlet fever
- ☐ Mumps
- ☐ Other

Adult Illnesses

- ☐ Glaucoma
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Stomach ulcers
- ☐ Hepatitis or jaundice
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Kidney stones
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Nervous breakdown
- ☐ Depression
- ☐ Epilepsy (seizures)
- ☐ Stroke or paralysis
- ☐ Diabetes (sugar)
- ☐ Arthritis
- ☐ Gout
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Anemia (low blood)
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Hay fever
- ☐ Pneumonia
- ☐ Pleurisy (chest pain)
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Heart disease
- ☐ Angina (chest pain)

Hospitalizations

Have you ever been hospitalized? YES ☐ NO ☐

IF YES, please list the hospitalizations in order from first to last, giving the date and reason. Please include medical illnesses (heart disease, kidney disease, depression, nervous breakdown, etc.) and surgical illnesses (appendectomy, tonsillectomy, gallbladder surgery, etc.); also specifically any hospitalization(s) or surgery for chest, lung or heart disorders:

	Year	**Reason**		**Year**	**Reason**
1)	_____	_____	6)	_____	_____
2)	_____	_____	7)	_____	_____
3)	_____	_____	8)	_____	_____
4)	_____	_____	9)	_____	_____

Injuries

Have you ever had a major injury?..... YES _____ NO _____

if YES, check below:

YEAR

_____ Head injury …….. _____

_____ Eye injury …….. _____

_____ Neck injury …….. _____

_____ Back injury …….. _____

_____ Fracture of _____ _____

_____

_____

_____ Chest injury, such as fractured rib or spine…… _____

_____

_____

_____ Automobile Injury …… _____

_____ Gunshot wound……..…… _____

_____ Other ……..... _____

_____

_____

Transfusions

Have you ever received a blood transfusion? …….. YES _____ NO _____

If YES, state the reason for the transfusion:

Vaccinations

If you have had any of the following, check and if possible give the date of the last vaccination or booster:

YEAR

_____ Smallpox …….. _____

_____ Poliomyelitis (polio) ……... _____

_____ Tetanus vaccination (polio) ……... _____

_____ Influenza …….……... _____

_____Pneumococcal (pneumonia) ……... _____

Medications

Please list below all medications you now take or have taken in the past 6 months. Please include aspirin, laxatives, nerve pills, birth control pills, vitamins, sleeping pills, etc., whether they are prescription drugs or not:

	Name (if known)	Reason taken	How often; If daily, how many a day
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Allergies

Are you allergic to any medication or do you have any other allergies?

Yes ☐ No ☐ If YES, please list the agent to which you are allergic and state the type of reaction you experience:

Medication _____ Type of reaction_____

_____ _____

_____ _____

Other _____ _____

_____ _____

Specific Pulmonary Symptoms-Please answer the following questions:

COUGH

1. Do you **USUALLY** cough first thing in the morning?..... YES_____ NO_____
2. Do you **USUALLY** cough at other times during the day or night? ..... YES_____ NO_____

If answer to 1 or 2 is YES, answer 3, 4, and 5. If both are No, proceed to next topic.

3. Do you cough on most days as much as three months of the year? ..... YES_____ NO_____

4. How many years have you had this cough? _____

5. Do you cough more on any particular day of the week? ..... YES_____ NO_____
If YES, which day? _____

PHLEGM, SPUTUM OR MUCUS

1. Do you USUALLY bring up phlegm (sputum, mucus) from your chest first thing in the morning?
YES_____ NO_____

2. Do you USUALLY bring up phlegm (sputum, mucus) from your chest at other times in the morning?
YES_____ NO_____

3. Do you bring up phlegm (sputum, mucus) from your chest on most days for as much as three months of the year?
YES_____ NO_____

4. For how many years have you raised phlegm (sputum, mucus) from your chest? _____

5. What is the usual color of the phlegm (sputum, mucus) you bring up from your chest?
Don't know _____ Clear _____ White _____ Yellow _____ Green _____

Other (give details) _____

HEMOPTYSIS

1. Have you coughed up blood from your chest in the past 2 years? ..... YES_____ NO_____

2. If YES, when, how many times, give details _____

_____

3. Did you have a chest x-ray..... YES_____ NO_____

WHEEZING, WHISTLING, CHEST TIGHTNESS

1. Have you ever noticed any wheezing, whistling or tightness in your chest?
YES_____ NO_____ If NO, proceed to **BREATHLESSNESS.**

2. Which symptoms have you experienced?

Only wheezing and whistling _____ Only chest tightness _____ Both _____

3. At what age did your wheezing, whistling or chest tightness first occur? _____

4. When did the wheezing, whistling or tightness occur last? _____

5. How frequently have you experienced this wheezing, whistling or chest tightness? Daily _____ Nightly _____

Few times a week _____ Few times a month _____ Few times a year _____ Only rarely _____

6. Is your wheezing, whistling or chest tightness brought on or made worse by exposure to; House Dust _____

Other dusts or fumes at home _____ Contact with animals _____ Contact with plants or pollen _____

Dusts, gases, or fumes at work _____ Tobacco smoke _____ Other _____

7. Is your wheezing, whistling or chest tightness worse on any particular day of the week?

YES_____ NO_____ If YES, what day or days? _____

Do you always have it on Mondays? YES_____ NO_____

8. Is your wheezing, whistling or chest tightness worse:

a. Before work_____
b. After beginning work_____
c. With exercise_____
d. At night or when away from work_____

If symptoms are worse after beginning work, how many hours after beginning the shift? _____ and how long do symptoms last? _____

9. Are you allergic to anything? YES_____ NO_____

If YES, what? _____

10. After a week or more away from work, do you notice any change of breathing after return to work? _____

BREATHLESSNESS

1. Are you disabled by any condition other than lung disease which interferes with your walking?
YES_____ NO_____
If YES, proceed to **CHEST ILLNESS.**

2. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?
YES_____ NO_____

3. Do you notice shortness of breath walking with other people of your own age on level ground?
YES_____ NO_____

4. Do you have to stop for breath when walking at your own pace on level ground?
YES_____ NO_____

5. Are you short of breath when washing or dressing? YES_____ NO_____

6. Are you short of breath at rest? YES_____ NO_____

7. Is your shortness of breath worse on Mondays? YES_____ NO_____

CHEST ILLNESS

1. During the past 3 years have you had chest colds, bronchitis, or pneumonia?
None _____ 2 or 3 bouts _____ More than 3 bouts _____

2. During the past 3 years have any of these kept you off work or in bed for as long as a week?
YES_____ NO_____

3. When was your last cold? _____

TOBACCO SMOKING

1. Have you ever smoked tobacco? YES_____ NO_____

If NO, skip to **THE NEXT PAGE**

2. Have you ever smoked cigars regularly? YES_____ NO_____

a. How many years? _____ b. How many cigars per day? _____

c. Do you still smoke cigars? YES_____ NO_____

d. Do you (did you) inhale? YES_____ NO_____

3. Have you ever smoked a pipe regularly? YES_____ NO_____

a. How many years? _____ b. How many pipefuls a day? _____

c. Do you still smoke a pipe? YES_____ NO_____

d. Do you (did you) inhale? YES_____ NO_____

4. Have you ever smoked cigarettes? YES_____ NO_____

5. During your total years of cigarette smoking, what is the average number of packs of cigarettes you smoked each day? _____

6. How many total years have you smoked cigarettes? _____

7. Have you stopped smoking? YES_____ NO_____

If YES, how long has it been since you stopped smoking

a. _____ months b. _____ years.

ALCOHOL

Have you ever used alcoholic beverages?..... YES_____ NO_____

If YES. check below:

_____ none for _____ years.

_____ at present.

_____ socially only _____ daily _____ to excess on occasions.

HOBBY AND LEISURE HISTORY

Do you have contact with animals in your home?.....YES_____ NO_____

If YES, check below:

_____ birds
_____ dogs
_____ cats
_____ other

Do you have other hobbies in which you may inhale fumes or dust? .....YES_____ NO_____

If YES, please give details_____

_____

OCCUPATIONAL HISTORY:

Check one or more:

_____ self-employed _____ housewife

_____ employed (by others) _____ student

_____ retired _____ unemployed

If employed or self employed, describe the type of work: _____

Please list below all previous occupations from your first job to your current job:

Have you ever worked at any of the following occupations ……. YES_____ NO_____

If YES, check and indicate how long:

_____ in a foundry …….. how long? _____

_____ in a coal mine ……...how long? _____

_____in any other mine; list the type …… how long? _____

_____in a quarry…… .how long? _____

_____in a pottery…….how long? _____

_____in a cotton, flax or hemp mill ……how long? _____

_____ as a tunnel worker ……how long? _____

_____ as a rock cutter.....…….how long? _____

_____ in manufacturing beryllium……..how long? _____

_____ in manufacturing ceramics, glass or abrasives..……how long? _____

_____in any other job with exposure to dust, gas or fumes……how long? _____

Describe the job_____
_____
_____

EDUCATION

Circle year completed:

Grade school	1	2	3	4	5	6	7	8
High school	1	2	3	4				
College	1	2	3	4				
Other	_____							

FAMILY HISTORY:

Please check and describe where appropriate:

Father

_____ living age _____ illnesses _____

_____ dead age at death _____ cause _____

Mother

_____ living age _____ illnesses _____

_____ dead age at death _____ cause _____

Brothers and Sisters

_____ living age _____ illnesses _____

_____ living age _____ illnesses _____

_____ living age _____ illnesses _____

_____ living age _____ illnesses _____

_____ dead age at death _____ cause _____

_____ dead age at death _____ cause _____

_____ dead age at death _____ cause _____

_____ dead age at death _____ cause _____

If any of your blood relatives have had the following conditions, check and indicate their relationship to you:

_____ asthma _____

_____ emphysema _____

_____ bronchitis _____

_____ tuberculosis _____

_____ diabetes _____

_____heart disease _____

_____ high blood pressure _____

_____ stroke _____

_____ arthritis _____

_____ gout _____

_____ epilepsy (seizures) _____

_____ cancer _____

_____ other _____

REVIEW OF SYSTEMS

Weight
Present _____ Usual _____
Any weight change in the past year? YES_____ NO_____

Skin
_____ chronic or recurring skin condition
_____ lump or growth on skin
_____ change in color of skin

Eyes
_____ glasses
_____ decreased vision
_____ pain in eyes

Ears
_____ difficulty hearing
_____ earaches
_____ discharge from ears
_____ buzzing or ringing in ears

Nose and throat
_____frequent sneezing
_____ nose continually stuffed or runny
_____ recurrent sore throats; persistent hoarseness

Cardiopulmonary
_____ chest pain
_____ shortness of breath cough
_____ bloody sputum
_____ wheezing
_____ unusual heart beat

Gastrointestinal
_____ frequent heartburn or indigestion
_____ nausea or vomiting
_____ stomach pain
_____ diarrhea
_____ constipation
_____ blood in stool

Genitourinary
_____ painful urination
_____ frequent urination
_____ bloody urine
_____ discharge (penile or vaginal)

Musculoskeletal
_____ painful joints
_____ sore muscles
_____ back pain

Neuropsychiatric
_____ frequent or severe headaches
_____ dizziness or faintness
_____ more nervous than average person

For Women Only
_____ periods irregular
_____ bleeding between periods
Date last menstrual period _____

Please check below if you have had any of the following in the past two years and indicate the date:

_____ complete medical examination _____

_____ electrocardiogram _____

_____ blood count _____

_____ blood chemistries _____

_____ urinalysis _____

_____ chest x-ray _____

_____ pulmonary function tests (breathing test) _____

Were you referred by a physician? YES_____ NO_____

If YES, give his/her name and address:

_____

_____

_____

_____

_____

Name _____ SS# _____

Medication _____

Do you feel (better, worse, the same) with this medication?

Does your chest feel (better, worse, the same) with this medication?

Does your breath feel (better. worse. the same) with this medication? Can you do (more, less, the same) on this mediation?

Do you have (more, less, the same) shortness of breath with this medication? If you had wheezing or chest tightness, is it (better, worse, the same)?

Do you cough (more, less, the same) on this medication?

Has the character of the cough changed (intensity. duration, time of day or night)?

Has your sputum changed (thinner, thicker, same)? Is your sputum (easier, harder, the same) to raise?

Do you have (more, less, the same) number of colds? Have you changed your smoking habits? (Give details)

_____

_____

Do you (always, usually, rarely, never) take your medications?

Do you have any side effects from this medication?

Headache	_____	Rapid heartbeat	_____
Dizziness	_____	Sweating	_____
Fainting	_____	Nausea	_____
Fatigue	_____	Vomiting	_____
Insomnia	_____	Indigestion	_____
Tremor	_____	Diarrhea	_____
Nervousness	_____	Constipation	_____
Anxiety	_____	Trouble Urinating	_____
Palpitations	_____	Impotence	_____
(Heart skipping)	_____	Other	_____

Physician: See reverse side of this sheet for physical examination information.

For Physician's Use
PHYSICAL EXAMINATION