

HISTORY QUESTIONNAIRE (PULMONARY)

Patient Name: _____

Date: _____

SPECIAL PROBLEMS OR SYMPTOMS

1. Please describe any special problems or symptoms you would like to discuss with the doctor today:

2. How long have you had this problem? _____

3. Have you ever seen a doctor for this problem? _____ Yes _____ No

GENERAL SCREEN:

4. Are you allergic to any medications, foods or other substances?

_____ Yes _____ No IF YES, what? _____

5. List all medications you are currently taking:

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>DIRECTIONS FOR USE</u>	<u>STARTED</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. When is the last time you had a physical examination? _____

Continued on back ...

CHEST &	CRITICAL CARE	CONSULTANTS
A	M E D I C A L	G R O U P

7. List all illnesses (serious or chronic), and all hospitalizations, starting with the most recent. (Women: Do not list normal pregnancies.)

MONTH/YEAR	ILLNESS/HOSPITALIZATION/OPERATIONS	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Date of last Chest X-Ray or CT Scan of chest: _____

9. Date of 1st Labs Test: _____

10. Any prior history of surgeries: _____

11. Last Pulmonary Functions Studies: _____

12. Ever had a sleep study: Yes No

If yes, when: _____