

Lung Care Group

Patient Questionnaire-Pulmonary

Name	Age	Sex	Weight	Date	
Referring Doctor:					
Your Occupation:					
Chief Problem That Brings You Here:					
Medical History	You		Family		*List family member/comments
	Yes	No	Yes	No	
Emphysema					
Asthma					
Cancer, type:					
High Blood Pressure					
Diabetes					
Tuberculosis (TB)					
Stomach Ulcers					
Heart Disease or Heart Attack					
Stroke					
Surgery (what type, year, and surgeon's name):					
Known Allergies to medication (foods, x-ray, dye, etc.):					
Current medications, including over the counter drugs (Please bring bottles to appointment):					
Immunizations:					
Smoking History	Yes	No	Packs per day	Comments	
Do you smoke now?					
Have you smoked in the past?					
Alcohol Intake	Yes	No	Comments/Amount		
Current Intake					
Medical History	Yes	No	Comments		
New plants in home					
Pets					
Exposure to asbestos/silica					

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Name	Date

Do not write in this space

Review of Systems		
Are you bothered by:	Yes	No
1. Fever, chill, night sweats		
2. Weight gain or loss		
3. Difficulty falling or staying asleep		
4. Fatigue, lack of energy		
5. Double vision, dry eyes		
6. Glaucoma, cataracts		
7. Headaches		
8. Hearing loss, ringing in ears		
9. Sinus troubles, nosebleeds		
10. Sores in nose or mouth		
11. Hoarseness		
12. Chest pain or discomfort		
13. Palpitations, irregular heartbeat		
14. Swelling of ankles or hands		
15. Shortness of breath – rest, activity, at night		
16. Wheezing		
17. Cough		
18. Do you cough up anything?		
19. Is there blood in it?		
20. Difficulty swallowing, heartburn		
21. Pain in stomach		
22. Nausea, vomiting		
23. Poor appetite		
24. Bloody or black stools		
25. Diarrhea or constipation		
26. Difficulties with urination		
27. Joint pain, swelling, or stiffness		
28. Skin rash or itching		
29. Hands change color when cold		
30. Tremor, seizures, or blackouts		
31. Depression or anxiety		
32. Heat or cold intolerance		
33. Unusual bleeding or bruising		
34. Anemia		
35. Other:		

Reviewed by: _____ Date: _____