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Valley Medical Group
Valley Health System
Pulmonary & Sleep Medicine

Pulmonary Information Questionnaire

Name_____ Date_____

Referring Physician_____

Date of Birth_____ Marital Status_____ # of Children _____

Please answer each question to the best of your ability.

Describe the principal reason(s) for your visit:

_____

Breathing:

Do you ever have shortness of breath? ☐___No ☐ ___Yes
Check all that apply:
☐ At rest (sitting) # of years_____
☐ After walking (level) # of years_____
☐ After climbing stairs # of years_____
☐ When lying on your back? # of years_____

Do you ever have wheezing? ___ No ___ Yes: When? _____

Do you have a cough? ___ No ___ Yes: Rarely _____ Occasionally _____ Often _____

When and how long have you had the cough?
☐ First thing in the morning _____months _____years
☐ At other times during the day or night _____months _____years
☐ On most days (for as much as 3 months of the year) _____months _____years
☐ At night _____months _____years
☐ Cough wakes you up _____months _____years
☐ At work (especially) _____months _____years

Do you cough or wheeze more in any particular season of the year? _____ Which season? _____

Do you bring up phlegm? ☐No ☐Yes

If yes, how much per day? _____less than a teaspoon _____ # of teaspoons
_____1/4-1/2 cup _____1/2–1 cup ____1 cup or more

What color is your phlegm? ____White ____Yellow ____Green ____Pink ____Red

Respiratory History: Have you ever had, or been diagnosed with: (please check if yes, and enter date or number of years)

☐ Asthma_____
☐ Emphysema_____
☐ Pleurisy_____
☐ Lung Scar_____
☐ Lung surgery _____
☐ Lupus_____
☐ Congestive heart failure_____
☐ Chronic bronchitis _____
☐ Post nasal drip _____
☐ Thrombophlebitis _____
(blood clot to leg/arm)
☐ Pulmonary embolism (blood clot to lung)_____
☐ Pneumonia_____
☐ Tuberculosis_____
☐ Sinus problems/ sinusitis/ sinus pain _____
☐ Recurrent bronchitis_____
☐ Sarcoidosis_____
☐ Hypercoagulability (thick blood)_____
☐ Nasal polyps _____
☐ Sleep apnea _____
☐ Interstitial fibrosis _____

History of Cigarette Smoking:

☐ ___ Never smoked
☐ ___ CURRENTLY smoke _____#packs/day _____# years smoking
☐ ___ FORMER smoker _____#packs/day _____# years smoked _____# years stopped

Allergies: Are you allergic to any of the following? Please specify:

☐ ___ Medications (antibiotics, others): _____
☐ ___ Environmental (e.g., pollen, mold, dust, animals): _____
☐ ___ Latex
☐ ___ X-ray dye/ Iodine_____
☐ ___ Shellfish/seafood_____
☐ ___ Eggs_____
☐ ___ Pets _____
☐ ___ Other _____

Occupational History- Exposure: Current work: _____

Have you ever done any of the following types of work or had exposure to the following?
Check all that apply:

☐ ___ Construction: Type: _____ ___ Insulation work
☐ ___ Work with asbestos ___ Auto brake-lining
☐ ___ Elevator installation ___ Plumbing
☐ ___ Mining ___ Quarry work, foundry work, or sandblasting
☐ ___ Brick/masonry work ___ Farm Work
☐ ___ Prolonged exposure to birds ___ Navy yard, shipyard work
☐ ___ Prolonged exposure to animals or pets ___ Manufacturing glass, ceramics or abrasives
☐ ___ Millwork such as in a cotton, flax, or hemp mill: Which type? _____
☐ ___ Exposure to chemicals or fumes: Which types? _____
☐ ___ Work with solvents, plastics, acids, lead, TDI or PVC? Specify_____
☐ ___ Other chemical/fumes/silica exposure? Specify_____

Date of last Chest X-Ray _____ **Date of last CT scan of lungs**_____

Date of last skin test for TB: _____

Other Medical Problems: Have you EVER had any of the following medical problems?
List date, number of years:

☐ High blood pressure _____ ☐ Diabetes_____
☐ Heart disease _____ ☐ Heart Attack _____
☐ Rheumatic fever_____ ☐ Abnormal heart rhythm _____
☐ Ulcers _____ ☐ Liver problems _____
☐ Stroke _____ ☐ Anemia _____
☐ Bleeding problems_____ ☐ Kidney problems_____
☐ Blood Clot_____ ☐ Thyroid problems_____
☐ Cancer: _____Type:_____ ☐ Gastric reflux _____
☐ Severe Allergic Reaction _____ ☐ Rheumatoid arthritis _____
Glaucoma _____ Other_____

Other Symptoms: Have you EVER had any of the following symptoms or problems?

☐ ___ Poor appetite ☐ ___ Weight gain _____lbs. ___ Excessive appetite
☐ ___ Excessive sleepiness ___ Weight loss _____lbs. ___ Chest pain
☐ ___ Swelling of legs/ankles ☐ ___ Excessive snoring ___ Recent fever
☐ ___ Night sweats/chills ☐ ___ Joint pain ☐ ___ Muscle/bone pains

Medications:
Please list the names of all prescription and over the counter medications you are currently taking:

Name	Dose	# times/day	How long taking it

Please use additional sheets of paper if necessary to list all medications.

Hospitalizations/ Surgeries: Please list all prior hospitalizations and surgeries.

Year	Reason	Year	Reason

Personal Habits: Do you regularly drink any of the following?

☐ ___ Alcohol Daily quantity_____
☐ ___ Coffee- caffeinated Daily quantity_____
☐ ___ Cola- caffeinated Daily quantity_____
☐ ___ Tea- caffeinated Daily quantity_____

Family History: Check all that apply and specify the family member with the disease:

	Mother	**Father**	**Sister**	**Brother**	**Grand mother Maternal**	**Grand mother Paternal**	**Grand father Maternal**	**Grand Father Paternal**	**Other**
Deceased?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Asthma									
Emphysema									
Chronic bronchitis									
Bronchiectasis									
Interstitial fibrosis									
Sleep apnea									
Narcolepsy									
Insomnia									
Restless legs									
Cancer									
Diabetes									
Heart disease									
High blood pressure									
Stroke									
Other									

Snoring:

Do you snore? □ ___ No □___ Yes: □ Occasionally ___ □Usually___ □ Always___

If yes, do you snore loudly? _____ Number of years_____

Sleep:

How long does it take you to fall asleep at night? _____

Do you have difficulty falling asleep at night? ___ No ___ Yes Reason: _____

Bedtime _____ Morning wake-up time _____ Hours you usually sleep? _____ .

Do you sleep restlessly? □___ No □ ___ Yes, toss & turn □ ___ Yes, very restless

Do you ever experience a choking sensation while sleeping? □ ___ Yes □___ No

If yes, describe_____

Morning after sleep: Do you ever experience the following after a night's sleep?

____ Feel fully refreshed
____ Drowsiness/poorly refreshed
____ Headache
____ Sore or dry throat
____ Hallucinations
____ Mild drowsiness
____ Severe sleepiness
____ Dry mouth
____ Confusion
____ Paralysis/weakness

Daytime sleepiness: Do you feel sleepy in the daytime?

___Not at all
___Yes, mildly sleepy
___Yes, very sleepy, I have difficulty staying awake
___Yes, I have fallen asleep while driving or operating machinery

Do you take any of the following medications or drugs?

___ Sleeping pills
___ Pills to stay awake/stimulants
___ Sedatives/tranquilizers
___ Alcohol

Have you ever been told that you have or may have sleep apnea or other sleep disturbance?

□ ___ No □___ Yes What type?_____

Do you work shift-work? ___ No ___ Yes If yes, specify schedule _____

Do you frequently travel across time zones? ___ No □___ Yes

Are there other family members who have excessive snoring, sleep apnea or other sleep disorders?

___ No □___ Yes:
Specify:_____

_____