

No Va Pulmonary & Critical Care Associates, P.C.
New Outpatient Visit Questionnaire – p 1

Please answer the following questions to help your doctor evaluate you.

Your Name _____ **Date** _____

I. Pulmonary History **Reviewed with patient by physician: (initials)** _____

Check all that currently apply

- Intermittent cough (not related to a common cold)
- Frequent cough in the morning
- Sputum production _____ tablespoons per day
- Coughing up blood
- Chest congestion/tightness

Wheezing:

- Following a common cold
- With exercise
- Seasonally (spring/fall)

Smoking History

- Never smoked
- Quit smoking - When? _____
_____ average packs per day
_____ number of years smoked
- Currently smoking
_____ average packs per day
_____ number of years smoked

- Positive TB skin test in the past
- Exposure to TB
- Pneumonia – date _____

Shortness of breath:

- During strenuous exercise
- During moderate exercise
- During normal activity
- While at rest
- Awaken at night

How many blocks on level can you walk _____

How many flights of stairs can you climb _____

Date of last Chest X-Ray _____

Pneumococcal pneumonia vaccine – date _____

Influenza vaccine – date _____

Sleep

- snoring
- daytime sleepiness

II. Your Past Medical History

Birthplace: _____

Previous surgery (check, describe and indicate year) Year

- Lung Surgery _____ Year _____
- Heart Surgery _____ Year _____
- Other Surgery _____ Year _____

Other medical disease (check and describe) Year

- High Blood Pressure _____ Year _____
- High Cholesterol _____ Year _____
- Cancer _____ Year _____
- Heart Disease _____ Year _____
- Thyroid Disease _____ Year _____
- HIV Disease _____ Year _____
- Other _____ Year _____

Obstetrical history (for females)

Are you currently pregnant _____
Number of past pregnancies _____
Number of miscarriages _____
Other obstetrical complications _____

III. Your Family History

What diseases run in your family?

(circle, describe and indicate relative(s))

Relative(s)

Allergies
Emphysema
Asthma
Bronchitis
Heart Disease
Cancer

Others (circle if appropriate & specify relative)

Diabetes, stroke, kidney disease, anemia,
Sickle cell anemia, bleeding tendency,
arthritis, gout, TB, glaucoma,

IV. Your Social History

Are you working now? Yes No (circle)

What is (or was) your occupation?

Have you been exposed to asbestos, dust,
or strong chemicals? Yes No (circle)

Do you keep animals at home?

Yes No (circle and describe) _____

Approximately how many drinks of alcohol do you
consume in a week? _____

Have you travelled in last year? (list places and dates)

No Va Pulmonary & Critical Care Associates, P.C.
New Outpatient Visit Questionnaire – p 2

Reviewed with patient by physician (initials) _____

V. Medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

VI. Drug Allergies:

VII. Review of Symptoms, other than your breathing problem

Please check and describe problems you have experienced in the past three (3) months

- | | |
|---|---|
| <input type="checkbox"/> Fever, sweats or chills | <input type="checkbox"/> Swelling at the ankles |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Joint pains or muscle aches |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Fingers turn white and painful in the cold |
| <input type="checkbox"/> Weight loss of more than 5 pounds | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> Weight gain of more than 5 pounds
<i>How much? _____ pounds</i> | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Back or neck pain |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Unusual dizziness, faintness , loss of consciousness |
| <input type="checkbox"/> Hearing difficulty/ringing ears | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eye irritation | <input type="checkbox"/> Numbness or weakness of part of your body |
| <input type="checkbox"/> Blurred or double vision | |
| <input type="checkbox"/> Nose or sinus problems | <input type="checkbox"/> Rashes/Skin problems |
| <input type="checkbox"/> Post nasal drip | |
| <input type="checkbox"/> Dry eyes or mouth | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sleepiness in the daytime | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Breast discomfort | |
| | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Irregular or rapid heart beats | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Lymph gland swelling |
| | <input type="checkbox"/> Other Symptoms _____ |
| <input type="checkbox"/> Heartburn or indigestion | <input type="checkbox"/> No Other Symptoms |
| <input type="checkbox"/> Abdominal pain | |
| <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Hiatal hernia, gastroesophageal reflux | |
| <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Nausea or vomiting | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Liver disease | |
| <input type="checkbox"/> Difficult or painful urination | |
| <input type="checkbox"/> Frequent urination | |
| <input type="checkbox"/> Irregular menstrual periods or vaginal bleeding | |

All symptoms not marked have been reviewed with patient

To the Best of my knowledge this information is accurate and complete.

Patient Signature