Patient Respiratory Medical History

Date: \_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female DOB: \_\_\_\_\_\_\_\_

What problems are you having with your breathing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes you short of breath? (example walking, stairs, housework etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you produce any sputum or phlegm? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wheeze? Yes No If yes what may bring it on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you cough? Yes No If yes what may bring it on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does laughing, cold air, warm or hot air, talking on the phone: worsen your respiratory

 symptoms? If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have problems with postnasal drainage? Yes No. Do you have to frequently clear your throat?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you cough at night or during your sleep? Yes No

Do you currently cough up any blood? Yes No If yes how much and how often? \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever coughed up blood in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been exposed to Tuberculosis (TB)? Yes No If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a positive TB skin test? Yes No If yes explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to asbestos? Yes No If yes explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have problems with reflux or heart burn? Yes No If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had pneumonia? Yes No If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized for pneumonia? Yes No If yes when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a Pneumovax 23 vaccine for pneumonia? Yes No If yes when\_\_\_\_\_\_\_

Have you ever had a Prevnar 13 vaccine for pneumonia? Yes No If yes when\_\_\_\_\_\_\_\_\_\_

Have you had a flu vaccine? Yes No If yes when was your last vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with: COPD, Emphysema, Chronic Bronchitis

 Asthma as child Asthma as an adult

Any emergency room/urgent care visits regarding your Asthma? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken steroids (prednisone) currently, recently or in the past? If yes, please

explain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear oxygen? Yes No If yes when was it started\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any intolerance to aspirin? Yes No If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Does your intolerance to aspirin affect your breathing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a blood clot in your legs (DVT) or in a blood clot in your lungs (PE)?

 If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with chest pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What may bring on your chest pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What improves your chest pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Does it radiate Yes No If so where to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Intensity on a scale of 1 to 10 (10 being the worse) 0 1 2 3 4 5 6 7 8 9 10

Have you been told that you:

 Snore? Have pauses in your breathing during sleep? Tired during the daytime?

Any risk factors for the HIV virus: blood transfusion, multiple sexual partners, IV drug use

Do you have any? headaches blood in your stools fever chills diarrhea nausea

 vomiting joint aches rashes weight loss night sweats