Patient Respiratory Medical History

Date: _____

Patient Name_____ □ Male □ Female DOB:_____

Nationality: □ White □ Black □ Indian □ Asian □ Hispanic Other_____

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 post nasal 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 were to _____

Intensity of 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?

Have you ever smoked? □ Yes □ No If yes, do you still smoke? □ Yes □ No

If no, when did you quit?_____

If you have smoked or still smoke, How many years have you smoked? _____

How many packs a day do/did you smoke?_____

How much alcohol do you drink?_____

Do you use any street drugs? □ Yes □ No If yes please explain_____

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

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Are you □ Single □ Married □ Widowed □ Separated □ Divorced

Do you any pets at home? □ dog □ cat □ birds □ other animal exposures_____

Any recent travel in the last 2 years in the United States or out of the country? □ Yes □ No

If yes please explain._____

Have you been exposed to any □ toxic chemicals, □ chemotherapy, □ toxic drugs or □ radiation?

If yes please explain._____

Do you have any particular hobbies?_____

Occupation_____

Are you disabled? □ Yes □ No

Family History: Father □ alive □ deceased age _____Causes of death _____
Mother □ alive □ deceased age _____Causes of death _____

Is there a family history of COPD or emphysema ? □ Yes □ No Who_____

Is there a family history of Asthma □ Yes □ No Who_____

Is there a family history of pulmonary fibrosis? □ Yes □ No Who_____

Is there a family history of Lung Cancer □ Yes □ No Who _____

Is there a family history of Cystic Fibrosis □ Yes □ No Who_____

Do you have any? □ headaches □ blood in your stools □ fever □ chills □ diarrhea □ nausea □ vomiting □ joint aches □ rashes □ weight loss □ night sweats