Questionnaire for New Patients

Name

Date of Birth | Sex

Address

City | State | Zip code

Email address

Cell phone | Home phone

Would you like to receive text reminders for your appointments? ____________________

Allergies to medications

Current smoking status

Insurance

Preferred language

Emergency contact name | Phone number | Relationship

Preferred *local* pharmacy name and address

Preferred "*mail away*" pharmacy name

What is the reason for your referral to us?:

What tests have you had to evaluate this problem and where were they performed?

What treatments have been tried for this problem, and have they helped?

Please list your chronic medical condition.

Please list any hospitalizations with dates/facility/treating doctor (if known)

Please list any surgeries with dates/facility/surgeon (if known)

Have you ever seen a pulmonary specialist before? If so, please provide name and contact info.

Please list your primary care provider and (if you have one) your cardiologist, allergist, oncologist, ENT specialist and gastroenterologist.

Have you had an Echocardiogram (ultrasound of your heart)? If so, where and how long ago?

What are your medications?

Have you ever smoked or vaped nicotine? If so, clarify how much and for how many years and if still using tobacco or when you quit.

Do you drink alcohol? Estimate amount per day or per week.

Do you consume caffeine? Estimate amount per day.

List any current or previous recreational drug use (including marijuana, methamphetamine, heroin, cocaine, etc.).

Current exercise (type and frequency):

Have you had any excessive or frequent exposure to dust, fumes, smoke, asbestos or other harmful substances?

Does your place of residence have a history of mold, either currently or previously?

Has your place of residence recently been under construction?

What are your hobbies?

Do you have any pets? (list type and number)

What is/was your occupation?

Were you ever in the military? If so, when and what did you do?

Where did you grow up/where have you lived?

Have you ever used a wood-burning stove inside your house?

Please list travel history outside of the United States (lifetime).

Do you have an Advance Directive or Living Will? (please provide office with a copy)

____

What is your insurance?

____

____

What is your preferred language?

____

What is your race and ethnicity?

____

What is your emergency contact information?

____

Name phone number relationship

When was your last flu shot?

____

Have you had the Pneumovax 23 pneumonia vaccine? If so, date?

____

Have you had the Prevnar 13 pneumonia vaccine? If so, date?

____

Have you had the adult RSV vaccine? If so, date?

____

Family History: please mark if you have a FAMILY HISTORY of any of the following conditions:

_____Arthritis

_____Autoimmune disease

_____Asthma

_____Blood Clot

_____Cancer

_____COPD

_____Hay Fever

_____Heart Disease

REVIEW OF SYMPTOMS

Mark if you experience any of the following symptoms or have the following diagnoses:

_____Fever
_____Unintentional weight loss
_____Weight gain
_____Fatigue
_____Night sweats
_____Chest pain
_____Heart disease
_____Congestive heart failure
_____Irregular/rapid pulse
_____Shortness of breath while lying flat
_____Awakening with shortness of breath
_____Lightheaded w/ exertion or fainting
_____Heart murmur
_____Swelling/edema of legs/feet
_____High blood pressure
_____Diabetes
_____Thyroid disease
_____Glaucoma
_____Frequent sore throat
_____Sinus problems
_____Stuffy nose/congestion
_____Postnasal drip
_____Seasonal/environmental allergies
_____Hoarseness
_____Difficulty swallowing
_____Indigestion/heartburn/reflux
_____Coughing while eating/drinking
_____Anemia
_____Abnormal/prolonged bleeding
_____Enlarged lymph nodes
_____Joint pain
_____Muscle weakness
_____Muscle pain
_____Frequent headaches
_____Anxiety/Depression
_____Asthma
_____Chronic Bronchitis/Emphysema
_____Pulmonary Fibrosis
_____Pneumonia
_____Collapsed lung
_____Cough
_____Sputum production
_____Cough with blood
_____Chest congestion
_____Wheezing
_____Shortness of breath with exertion
_____Shortness of breath at rest
_____Skin rashes
_____Snoring
_____Apnea (stop breathing) w/ sleeping
_____Excessive daytime sleepiness
_____Insomnia
_____Frequent nighttime awakening
_____Nighttime urination
_____Trouble with concentration/memory
_____Awaken with headache
_____Awaken with sore throat
_____Restless legs during sleep
_____Unusual behaviors during sleep
_____History BPH, difficulty w/ urination