SAINT LUKE'S PULMONARY CLINIC HISTORY FORM (TOTAL 4 PAGES)

Name: _____ Age: _____ Birth Date: __ /__ /_____

Referring Provider:_____Primary Care Provider:_____

PLEASE NOTE: If you are here for LUNG related issues, fill out pages 1, 3 & 4 (skip page 2)
If you are here for Sleep related issues, fill out pages 2, 3 & 4 (skip page 1)

Respiratory/Lung Health Questionnaire:

A. History of Cough:

1. Do you currently have a cough? **Y / N (if Yes, answer questions 2-8)**
2. If yes, how long has this been a problem? _____
3. Is there a certain time of the day you cough more? _____
4. Did it start with a sore throat, nasal congestion or sinus congestion? _____
5. Do you have a feeling of clearing throat frequently? _____
6. What makes the cough get better? _____
7. What makes the cough get worse? _____
8. Do you have uncontrolled heart burn/ acid reflux?_____

B. History of Coughing up Mucus/Phlegm/Sputum/Blood:

1. Do you cough up mucus / phlegm / sputum ? **Y / N (if Yes, answer questions 2-5)**
2. If yes, for how long has this been a problem? _____
3. What color mucus/phlegm/sputum do you have? _____
4. Any change in the amount or color of the phlegm lately? _____
5. Any blood streaks, blood clots or bright red blood in the phlegm? _____

C. History of Shortness of breath:

1. Do you feel shortness of breath/ short winded? **Y / N (if Yes, answer questions 2-7)**
2. If yes, for how long has this been a problem? _____
3. Which activities make you feel short of breath? _____
4. What makes your shortness of breath better? _____
5. Is shortness of breath worse upon lying down OR leaning forward? _____
6. Do you wake up at night from sleep feeling short of breath? _____
7. Do you lately feel tired with activities you used to do easily before? _____

D. History of Wheezing (Abnormal breath sound/ whistling sound)?

1. Do you hear yourself wheezing? **Y / N**
2. Do you feel chest tightness at times? **Y / N**
3. Do you use an inhaler or nebulizer treatments? **Y/ N**
4. Use of your rescue inhaler such as albuterol, combivent on average/day? _____

E. History of Chest Pain:

1. Do you feel any chest pain? **Y / N (if yes, answer questions 2-6)**
2. If yes, for how long has this been a problem?_____ Is it continuous or intermittent? _____
3. Which activities cause the chest pain?_____
4. What relieves the chest pain? _____
5. Is chest pain worse upon deep breathing or coughing? _____
6. Does the chest pain wake you up at night? _____

F. Do you have history of any of the following? (please check all that apply): Y/ N

☐ Hay fever (runny nose, itchy/watery eyes, sneezing) ☐ Weight loss ☐ fever ☐ night sweats

☐ Frequent sinus infections ☐ Recurrent pneumonia ☐ Frequent bronchitis

☐ Exposure to dust, fumes, farming, chemicals, mold, asbestos, metals **(please circle)**

PLEASE FILL OUT THIS PAGE **ONLY IF** YOU ARE HAVING SLEEP RELATED ISSUES

Name: _____ Age: _____ Date of Birth: ___/___/_____

1. Have you ever had a sleep study? **Y / N**
2. Have you ever used CPAP or BiPAP machine during your sleep? **Y / N**
3. What time do you go to bed? _____
4. What time do you get up in the morning? _____
5. How long does it take you to fall asleep? _____
6. What do you do few hours prior to bedtime? _____
7. Do you drink any alcohol or caffeinated drink within 4 hours prior to bedtime? **Y/ N** _____
8. Do you take any sleep aids to help fall asleep? **Y / N**_____
9. Do you have a preferred sleeping position? **Y/ N:** Back / Stomach/ Side (circle one if yes)
10. Has anyone told you that you snore or stop breathing during sleep or both? **Y / N**_____
11. Have you awakened with a gasp, snoring, shortness of breath or choking? **Y / N**_____
12. How many times do you wake up from sleep? _____
13. What wakes you up from sleep? _____
14. Do you have an uncomfortable feeling in your legs during sleep? _____
15. Do you wake up tired or refreshed from sleep? _____
16. Do you wake up with a headache in the morning? _____
17. Do you have a dry mouth upon awakening from sleep? _____
18. Caffeine use (coffee, tea, soda etc.): **Y / N** _____drinks/day
19. Alcohol use: **Y/ N** _____drinks/day
20. Do you feel drowsy or sleepy while driving / operating machineries? **Y / N** _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times.
Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:
0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing
It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch without alcohol	_____
8. In a car, while stopped for a few minutes in the traffic	_____

TOTAL SCORE: _____

Thank you for your cooperation.
Understanding your Score**: 0 to 10**- normal range in healthy adults, **11-14**: mild sleepiness
15-17 moderate sleepiness, **18 or higher**: severe sleepiness

PAST MEDICAL/ SURGICAL HISTORY: (Circle all the applicable ones)

Asthma
COPD
Lung scarring / Pulmonary Fibrosis
Blood clot in lungs/legs
Pneumothorax (collapsed /punctured lung needing chest tube)
Pleural effusion (fluid around the lung)
Respiratory failure
Tracheostomy
Sinus surgeries
Lung surgery
High blood pressure
High cholesterol /lipids
Heart attack / Stent in heart
Atrial fibrillation
Stroke
Kidney disease
Thyroid disease
Liver disease
Rheumatoid Arthritis / Lupus
Cancer (specify):_____

OTHER (Please specify): _____

History of Surgeries: _____

_____

SOCIAL HISTORY:

Marital Status: Married / Divorced / Single / Widowed
Number of Children: Daughters: _____ Sons:_____
Occupation: _____ **If retired, type of work done:** _____
Do you have any pets (if yes, specify): _____

Do you currently smoke? **Y / N**
If yes, for how long have you been smoking? _____ How many packs/ day_____
If quit, how many years did you smoke and how much? _____
History of second hand smoke exposure? **Y/ N**. If yes, specify_____

FAMILY HISTORY:

Family Member	**Living**	**Deceased**	**Age/ Age at Death**	**Health Problems if any**
Mother				
Father				
Sister				
Brother				
Children				

Name:_____ **Today's Date:**_____

ALLERGIES (Drug, Food, Environmental etc):_____

CURRENT MEDICATION LIST : (please attach list if you have one)

☐ **See attached list**

Name	**Dose**	**Frequency**	**Name**	**Dose**	**Frequency**

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING? (check only the applicable ones):

Constitutional ☐ Fever ☐ Night sweats ☐ Unexplained weight loss / weight gain ☐ Fatigue	**Hematologic** ☐ Anemia (low hemoglobin count) ☐ Easy bruising / bleeding ☐ Swollen glands ☐ History of blood tranfusion
Ear, Nose & Throat ☐ Sore throat ☐ Nasal / Sinus congestion ☐ Thrush in mouth ☐ Hoarseness of voice	**Musculoskeletal** ☐ Hand joint pain / swelling ☐ Back pain ☐ Joint stiffness in the morning ☐ History of trauma to chest wall or abdomen
Eyes ☐ Dryness of eyes ☐ Itchy / watery eyes ☐ blurred vision ☐ Eye problem (not corrected by glasses)	**Skin** ☐ Skin rash ☐ Dry skin ☐ Itching ☐ Psoriasis
Pulmonary ☐ History of asthma in childhood ☐ Difficulty breathing while lying down ☐ Difficulty breathing at night ☐ History of Tuberculosis(TB) / TB skin test	**Neurologic** ☐ Headache ☐ Seizure ☐ Trouble with balance ☐ Dizziness / passing out
Cardiac ☐ Palpitation (feeling of heart beating) ☐ Leg swelling / Ankle swelling ☐ Heart murmur ☐ Abnormal heart rhythn	**Endocrine** ☐ Heat intolerance ☐ Cold intolerance ☐ Excessive thirst ☐ High blood sugar
GI ☐ Nausea / Vomiting ☐ Diarrhea ☐ Trouble swallowing ☐ Abdominal pain ☐ Black stools / bleeding from bowel	**Gynecologic** ☐ History of endometriosis ☐ History of 2 or more miscarriages ☐ Birth control pill use ☐ Uterine or cervical cancer ☐ Post menopause
GU ☐ Night time urination / Frequent urination ☐ Blood in urine ☐ Abnormal kidney function ☐ Difficulty starting stream of urine	**Sleep** ☐ Snoring ☐ Stop breathing during sleep ☐ Wake up tired/ un refreshed after sleep ☐ Take deliberate nap during day ☐ Leg cramps during sleep ☐ Use CPAP or BiPAP for sleep apnea

PATIENT'S SIGNATURE: _____ **Today's Date:** ____/____/_____