Desert Pulmonary & Sleep Consultants, PLC

Patient Questionnaire for Pulmonary Evaluation

Name:_____ DOB:_____/_____/_____ Today's Date ____/____/_____

Please answer the following questions and requested information the best you can. This is to assist the doctor in evaluating your problems and also serve as a reminder of questions you might like to ask. Thank you.

I. PAST MEDICAL HISTORY (Check yes or no and list year of the illness)

	YES	NO	YEAR
Atrial Fibrillation			
Anemia			
Arthritis			
Asthma			
Back problems			
Bleeding tendency			
Bronchiectasis			
Bronchitis			
Cancer			
COPD			
Diabetes			
Emphysema			
Environmental Allergies			
Hepatitis			
Heart disease			

	YES	NO	YEAR
Hypertension			
Kidney disease			
Pleurisy			
Pneumonia			
Polio			
Pulmonary Fibrosis			
Rheumatic Fever			
Sleep apnea			
Thyroid disease			
Tuberculosis			
TB exposure			
Ulcer disease			
Valley fever			
Other			

II. SURGICAL HISTORY (Check yes or no and list year of procedure)

	YES	NO	YEAR
Appendix			
Back			
Breast			
Bronchoscopy			
Cystoscopy			
Gallbladder			
Heart			
Hernia			
Hysterectomy			

	YES	NO	YEAR
Lung			
Nasal Polyps			
Prostate			
Sterilization			
Stomach			
Thyroid			
Tonsils / Adenoids			
Varicose veins			
Other			

III. FAMILY HISTORY (Have any blood relatives had any of the following? Check yes or no and list the family member)

	YES	NO	FAMILY MEMBER
Allergy			
Asthma			
Bleeding tendency			
Bronchitis			
Cancer (type)			
Diabetes			
Emphysema			

	YES	NO	FAMILY MEMBER
High blood pressure			
Heart disease			
Mental illness			
Overweight			
Pulmonary Embolism			
Sleep Apnea			
Other			

Race _____ Language _____ Ethnicity _____ I prefer not to complete this section ☐

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IV. CURRENT MEDICATIONS

MEDICATION	DOSAGE
PHARMACY NAME:	**FAX/PHONE:**

V. MEDICATION ALLERGIES (Please list all drug allergies)

MEDICATION/DRUG	REACTION(S)

V. IMMUNIZATION HISTORY (Indicate year received immunization)

	YEAR		YEAR
BCG		Tetanus	
Flu		Other	
Pneumonia			

VI. SMOKING HISTORY (Check all that apply)

	YEAR STARTED	LAST YEAR USED	USAGE PER DAY?
Cigarettes			
Cigars			
Pipe			
Chewing Tobacco			
Marijuana/Other			

VII. CAFFEINE/ALCOHOL HISTORY

	AMOUNT PER DAY		AMOUNT PER DAY
Coffee		Energy Drinks	
Tea		Beer/Wine	
Soft Drinks		Liquor/Mixed Drinks	

VIII. HEIGHT/WEIGHT HISTORY

My Usual Weight is:		pounds
Maximum Weight Attained		pounds

My Ideal Weight:		pounds
My Height		inches

IX. SOCIAL HISTORY

MARITAL STATUS		AGES OF CHILDREN	M	F		Y	N
Married/Partnered					Exposure to Asbestos?		
Divorced/Separated					Exposure to smoke or chemical fumes?		
Widow(er)					**OCCUPATION:**		
Single							