NAVAL MEDICAL CENTER PORTSMOUTH
PULMONARY CLINIC
PATIENT QUESTIONNAIRE

DATE: __________

NAME: ______________________________________ AGE: ______

PRIMARY CARE or REFERRING PROVIDER: ______________________________________

Why are you seeing a lung doctor? ____

____

How long have you had this problem? ____

MEDICATIONS: Please list all medications including over-the-counter meds and supplements. This can also be done on a medication reconciliation sheet. Please list any respiratory home equipment you have (spacer, peak flow meter, nebulizer, etc.)

____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
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____________________________ ____________________________

ALLERGIES/ADVERSE REACTIONS TO MEDICATIONS:

____

MEDICAL HISTORY: Have you ever been diagnosed with any of the following conditions? Please check all boxes that apply

□Asthma	□Emphysema/COPD	□Chronic Bronchitis
□Sarcoidosis	□Broken Rib(s)	□Pulmonary Hypertension
□Pneumonia	□Lung Cancer	□Bronchiectasis
□Seasonal allergies	□Sinus Problems	□Abnormal Heart Rhythm
□Heart Attack	□Heart Failure	□High Blood Pressure
□Heart Valve Disorder	□High Cholesterol	□Diabetes
□Sleep Apnea	□Depression	□Anxiety
□Blood Clots	□GERD/Reflux	□+TB Skin Test/PPD
□Pulmonary Fibrosis	□Connective Tissue Disease	□Peripheral Vascular Disease

□Cancer:____

□Other:____

Do you currently use oxygen? If so, which company provides your oxygen? _______________

Surgical History: Please list all prior surgeries.

Procedure	Approximate Date
______________________________________	____________________
______________________________________	____________________
______________________________________	____________________
______________________________________	____________________

FAMILY HISTORY: List any biological family members and their known diseases though please focus on: lung diseases (emphysema, COPD, asthma), blood clots, strokes, cancers, cystic fibrosis, and connective tissue diseases (rheumatoid arthritis, lupus, scleroderma, etc.)

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

IMMUNIZATIONS:		
	Influenza	Date: ____________________________
	Pneumovax	Date: ____________________________
	Prevnar	Date: ____________________________
	Pertussis/TDap	Date: ____________________________

SYMPTOMS: Have you had any of the following symptoms for the past 4 weeks? (Check all that apply.)

□Weight Loss	□Weight Gain	□Fever or Chills	□Night sweats	□ Fatigue
□ Headaches	□ Chest pain	□ Palpitations	□ Chest tightness	□ Passing out
□ Dizziness	□ Wheezing	□ Cough	□ Sore throat	□ Hoarseness
□ Constipation	□Sneezing	□Nasal drainage	□Waking up	□Nasal congestion
□short of breath	□Snoring	□ Diarrhea	□Hearing loss	□Ear pain
□Heartburn	□ Nausea	□Abdominal pain	□Regurgitation	□ Muscle aches
□Vomiting	□ Leg swelling	□ Back pain	□ Joint pain	□Rash/Lumps

□Frequent urination □Coughing up blood □Shortness of breath □Unable to lay flat
□Urination at night
□Other:____

NICOTINE USE:	Type	Amount	Length of time
	□Cigarettes	________________	____________
	□Cigars	________________	____________
	□Chewing	________________	____________
	□Pipe	________________	____________
	□Electronic Cigarette	________________	____________
	□Hookah	________________	____________

ALCOHOL USE: **Type** □**Beer** □**Wine** □**Liquor**
How much weekly? ________ ________ ________

CAFFEINE USE: **Type** **How much daily**
□**Coffee/Tea** ________________
□**Soda/Energy drinks** ________________

OCCUPATION(S): Please list current and previous occupations- civilian and military. Especially interested in the following work: electrician, boiler technician, hull technician, mechanic, plumber, baking/mill worker, mining, welder, mason, foundry/quarry worker, potter, ship builder, glass maker, farming/agriculture/husbandry, cement and concrete, cotton/textile, saw mill/furniture, painter.

	Job	How long
1.	____	________________
2.	____	________________
3.	____	________________
4.	____	________________
5.	____	________________

EXPOSURES: Have you ever been exposed to any of the following: (check all that apply)

□**Sandblasting** □**Burn pits** □**Silica/Mica/Talc** □**Coal dust**
□**Formaldehyde** □**Ammonia** □**Sulfur dioxide** □**Asbestos**
□**Beryllium** □**Grain dust** □**Radiation** □**Epoxy resin**
□**TMA (trimellitic anhydride)** □**Saunas/Hot tubs** □**TDI (toluene diisocyanate)**
□**Known person with Tuberculosis** □**DMA (diphenylmethane diisocyanate)**

DEPLOYMENT HISTORY & TRAVEL OUTSIDE THE USA:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

ANIMAL EXPOSURE:
□**Dog** □**Cat** □**Birds** □**Reptiles** □**Horse**
□**Other:**____

HOBBIES:
□**Woodwork** □**Gardening** □**Painting**
□**Other:**____

EXERCISE: What and how often? ____

LIVING ARRANGEMENTS:

Marital status? ___________________ **Children?**

____

Where were you born? Raised?

____

Ever live in the southwest United States? Ohio River Valley? _________________________

Where do you live currently? ____

How is the home heated? ___________

Do you have any concerns about water leaks or mold? ______________________________

PATIENT MEDICAL/LEGAL HEALTH CARE DOCUMENTS AND DIRECTIVES:

Do you have a Living Will or Advance Directive? ____________________________________

Do you have a Healthcare Power of Attorney? ____________________________________