Advanced Respiratory & Sleep Medicine

Pulmonary/Critical Care/Sleep Medicine/Internal Medicine

New Patient Medical Questionnaire

First and Last Name		Date:	
Please also complete the NEW PATIENT FACESHEET FORM. All information provided on these forms is confidential.			
Date/Place of Birth			
Primary Physician			
Referring Physician			

(any films, labs, appropriate documents must be provided to the office to better serve you.)

In your own words, please tell us why you are obtaining this medical evaluation and your goals for the visit.

Medical History:			
☐ *Allergies*	☐ *Depression*	☐ *Insomnia*	☐ *Sepsis*
☐ *Arthritis*	☐ *Diabetes*	☐ *Impotence*	☐ *Seizures*
☐ *Asthma*	☐ *High Cholesterol*	☐ *Kidney Problems*	☐ *Skin infections*
☐ *Alcoholism*	☐ *Gout*	☐ *Lupus*	☐ *Sleep Apnea*
☐ *Anxiety Disorder*	☐ *Heart Disease*	☐ *Liver Problems*	☐ *Thyroid Disease*
☐ *Bleeding Problems*	☐ *Heartburn/Reflux*	☐ *Meningitis*	☐ *Tuberculosis*
☐ *Bronchiectasis*	☐ *Hernia*	☐ *Pneumonia*	☐ *Trauma*
☐ *Cancer*	☐ *High Blood Pressure*	☐ *Rheumatoid Arthritis*	☐ *Urinary infections*
☐ *COPD*	☐ *Hospitalizations*	☐ *Sarcoid*	☐ *Ulcers*
☐ *STDs*	☐ *Syphilis*	☐	☐
Other:			

Surgical History: (please include approximate date)			
☐ *Tonsillectomy/Adenoids*	☐ *Bone/Joints*	☐ *Biopsies*	☐ *Gall Bladder*
☐ *Lung surgery*	☐ *Cosmetic*	☐ *Appendectomy*	☐ *Thyroidectomy*
☐ *Heart Surgery/Stents*	☐ *Dental*	☐ *Abdominal*	☐ *Splenectomy*
Other:			

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Family Medical History: (parents, grandparents, siblings)			
☐ *Allergies*	☐ *High Blood Pressure*	☐ *Diabetes*	☐ *Liver Problems*
☐ *Asthma*	☐ *Heart Disease*	☐ *Bleeding Problems*	☐ *Sarcoid*
☐ *Cancer*	☐ *COPD*	☐ *Lung Fibrosis*	☐ *Sleep apnea*
☐ *Lupus*	☐ *Thyroid Disease*	☐ *Kidney Problems*	☐ *Rheumatoid Arthritis*
☐ *Other disorders:*	☐	☐	☐
☐	☐	☐	☐

Inhalational exposures:		
Have you ever been exposed to the following for more than 3 months?		
☐ *Asbestos*	☐ *Brake pads*	☐ *Coal mining*
☐ *Heavy metal mining*	☐ *Lead*	☐ *Explosives/fire*
☐ *Warfare chemicals*	☐ *Gasoline*	☐ *Silica*
☐ *Glass/fiberglass*	☐ *Pesticides*	☐ *Pets (ie dog, cat, bird)*
☐ *Other:*	☐	☐

Smoking exposure:		
Have you ever smoked? (if yes then complete smoking history)	☐ *Yes*	☐ *No*
Please estimate how many years you smoked:		
Please estimate how many packs per day you smoked:		
If you quit, when did you quit?		
Have you had second hand smoking exposure?	☐ *Yes*	☐ *No*

Alcohol Use:		
Do you drink alcoholic beverages routinely? If so, what do you drink and how many drinks per day?		
Has anyone said that you have a problem with drinking?	☐ *Yes*	☐ *No*
Did you currently consume alcoholic drinks?	☐ *Yes*	☐ *No*

Any use of the following in your lifetime?		
☐ *Fen-phen or weight loss drugs*	☐ *Methotrexate*	☐ *Autoimmune medications (ie plaquinal, cytoxan)*
☐ *Amiodarone*	☐ *Steroids (ie prednisone, solucortef)*	☐ *Cancer medications (ie rituxan, 5FU)*

Recreational Drugs?			
☐ *Marijuana*	☐ *Cocaine*	☐ *Heroin*	☐ *PCP*
☐ *Ecstasy*	☐ *Anabolic steroids*	☐ *Other:*	

Immunizations:	
Pneumovax	*Date given:*
Influenza (flu-vax)	*Date given:*
Diphtheria/Pertussis/Tetanus(DPT)	*Date given:*
Hepatitis A	*Date given:*
Hepatitis B	*Date given:*
BCG	*Date given:*
PPD testing	*Date given:*

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Medications: (please list active and prior non-active 3 month history of medications, herbs, supplements)

Medication	Dose	Frequency	Reason

Please list all active and prior non-active nasal inhalers and bronchodilators below. *(ie flonase, nasonex, advair, xopenex, nebulizers)*

Allergies:

Medication	Reaction
Non-Medications (ie animals, trees,etc)	Reaction

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Review of Systems/Symptoms. Do you experience any of the following:			
General			
☐ *Weight loss or gain*	☐ *Fever or chills*	☐ *Weakness*	☐ *Poor appetite*
☐ *Fatigue*	☐ *Nightsweats*	☐ *Malaise*	☐ *Lethargic*
Head, Eyes, Ears, Nose, Throat			
☐ *Headache*	☐ *Tinnitus*	☐ *Hoarseness*	☐ *Stuffiness/earaches*
☐ *Decreased hearing*	☐ *Nose bleeds*	☐ *Tongue rash*	☐ *Nasal discharge*
☐ *Facial Pain*	☐ *Oral/lip ulcers*	☐ *Visual changes*	☐
☐ *Sore throat*	☐ *Throat itchy/full*	☐ *Metallic taste*	☐ *Bleeding gums*
Neck			
☐ *Lumps/mass*	☐ *Swollen glands*	☐ *Limited movement*	☐ *Pain/stiffness*
Cardiovascular			
☐ *Chest pain or tightness*	☐ *Palpitations*	☐ *Swelling in feet*	☐ *Faintness*
☐ *Lightheaded*	☐ *Fainting*	☐ *Cool feet or hands*	☐ *Bluish fingers or toes*
☐ *Hands tingle*	☐ *Leg cramps*	☐ *Varicose veins*	☐ *Blood clots*
Respiratory			
☐ *Cough*	☐ *Wheezing*	☐ *Coughing blood*	☐ *Shortness of breath*
☐ *Mucus with cough*	☐	☐	☐
Gastrointestinal			
☐ *Change in bowel habits*	☐ *Blood in stool*	☐ *Dark tarry stools*	☐ *Constipation*
☐ *Diarrhea*	☐ *Cough w/ swallow*	☐ *Vomiting*	☐ *Nausea*
☐ *Trouble swallowing*	☐ *Heartburn*	☐	☐
Urinary			
☐ *Urinate a lot*	☐ *Nighttime urine*	☐ *Urgency*	☐ *Burning or pain*
☐ *Hematuria(blood)*	☐ *Infections*	☐ *Kidney stones*	☐ *Incontinence*
Male Genital			
☐ *Hernia*	☐ *Erectile Dysfunc.*	☐ *Sores*	☐ *Testicular mass/pain*
Female Genital			
☐ *Painful/Heavy Periods*	☐ *Discharge/sores*	☐ *Use of oral contraceptive*	*Menopause*
Musculoskeletal			
☐ *Muscle or joint pains*	☐ *Muscle pain/stiff*	☐ *Swelling of joints*	☐ *Back pain*
☐ *Pain limits activity*	☐ *Weakness*	☐ *Knee pain*	☐ *Hip pain*
Skin			
☐ *Rashes*	☐ *Lumps/Bumps*	☐ *Itching*	☐ *Dryness*
☐ *Paleness*	☐ *Jaundice*	☐ *Erythema/red*	☐ *Burns*
Neurologic			
☐ *Dizziness*	☐ *Fainting*	☐ *Seizures*	☐ *Weakness, paralysis*
☐ *Numbness*	☐ *Tingling*	☐ *Tremor*	☐ *Vertigo*
☐ *Reduced coordination*	☐ *Reduced memory*	☐ *Reduced concentration*	
Psychiatric			
☐ *Nervousness*	☐ *Depressed mood*	☐ *Suicidal*	☐ *Lack enthusiasm*
☐ *Panic attacks*	☐ *Irritable*	☐ *Claustrophobic*	☐
Endocrine			
☐ *Heat or cold intolerance*	☐ *Excessive sweating*	☐ *Urinate a lot*	☐ *Over thirsty*
Hematologic			
☐ *Prior Transfusion*	☐ *Easy bleeding*	☐ *Anemia*	☐ *Use of blood thinners*
Allergy/Immunologic			
☐ *Watery eyes*	☐ *Rash*	☐ *Sneezing*	☐ *Nasal drip/congestion*
☐ *Prior testing*	☐ *Food allergy*	☐ *Dye allergy*	☐ *Pollen allergy*
Sleep			
☐ *Sleepy while driving*	☐ *Snoring*	☐ *Choking sensation*	☐ *Restless sleep/insomnia*

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For patients undergoing Sleep Evaluation, complete these questions:			
How much weight have you gained in last 5 years?			
Do you snore?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Been told that you stop breathing while asleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do you wake up gasping or choking?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Experience bedtime aching/twitching in legs at bedtime?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do you experience pain/discomfort during sleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do headaches awaken you?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Are you anxious or have racing thoughts at bedtime?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do others complain about your sleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do you have to wake up to go to the bathroom?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Is your sleep disturbed by anything in your environment?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do you talk/yell/walk during sleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Have you fallen out of bed?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Experienced bedwetting?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Nightmares?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Have you acted out a dream while asleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Experienced teeth grinding?	☐ *Yes*	☐ *No*	☐ *Sometimes*
How many hours do you sleep/night(average)?			
How many times do you wake up during bedtime?			
How long does it take to fall asleep?			
Are you sleepy/tired when starting or during the day?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do you have difficulty staying awake while driving?	☐ *Yes*	☐ *No*	☐ *Sometimes*
Do you nap?	☐ *Yes*	☐ *No*	☐ *Sometimes*
How many, if any, caffeinated drinks/day?	☐ *Tea/Coffee*	☐ *Soda*	☐ *Other*
Others symptoms/Describe:			

Epworth Sleepiness Scale: 0(low) to 3(high) chance of feeling sleepy	
SITUATION	*CHANCE OF SLEEPINESS (0-3)*
Sitting and reading	
Watching TV	
Sitting inactive in a public place (meeting, theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after eating lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
ESS Total Points	

This concludes the New Patient Medical Questionnaire. This information is confidential.

Other forms that may need to be completed:

1. HIPAA Authorization Form. Allows release of information to other providers.
2. New Patient Facesheet Form must also be completed before the 1st appointment.
3. Release of Medical Information Form. Allows provider to discuss confidential information with named persons.
4. Bed Partner Questionnaire. For those undergoing sleep disorder evaluation.