SANTIAM HOSPITAL embrace HEALTH™

# Pulmonary History Questionnaire

Name: ______________________

DOB: ______________________

## GENERAL INFORMATION

What is your primary problem with breathing? ______________________________________________

______________________________________ How long has this been present? _____months _____years

List other problems with your breathing (indicate duration in months/years):

a. ______________________________ b. ______________________________

c. ______________________________ d. ______________________________

Have you had a breathing problem diagnosed in the past? ☐ **Yes No** **If yes**, what was the problem and what treatment was recommended? ______________________________________________

Where was the diagnosis made? ______________________________ Did the treatment(s) help? ☐ **Yes No**

Did you have any breathing problems in childhood? ☐ **Yes No** Describe: ______________________________

## PAST MEDICAL AND SURGICAL HISTORY

- ☐ **Allergies**
- ☐ **Sinus infections**
- ☐ **Asthma**
- ☐ **COPD or Emphysema**
- ☐ **Sleep apnea**
- ☐ **Pneumonia**
- **How many?** __________
- ☐ **Bronchitis**
- **How many?** __________
- ☐ **Lung Cancer**
- ☐ **Congestive Heart Failure**
- ☐ **Heart Disease/heart attack**
- ☐ **Blood clot in legs or lungs**
- ☐ **Other lung disease** __________

**Other Medical/Surgical history:** ______________________________________________

______________________________________________

**Do you have an Advanced Directive?** ☐ **Yes No If yes**, where is it on file? ______________________

**Do you have a POLST?** ☐ **Yes No If yes**, where is it on file? ______________________

## SOCIAL HISTORY

**Place of Birth:** ______________ **Where else have you lived?** ______________________________

**Education highest level:** __________ **Employment Status:**______________

**What were your past occupation(s)?** ______________________________________________

**What your current occupation(s)?** ______________________________________________

**Have you ever been exposed to asbestos? Yes No If Yes describe:** ______________________________

**Have you ever been exposed to silica? Yes No If Yes describe:** ______________________________

**Have you ever worked in any of the following occupations or environments?**

| | | | | | |
|---|---|---|---|---|---|
| Y / N | Pulp mill Worker | Y / N | Mica Worker | Y / N | Pipe Coverer |
| Y / N | Saw mill Worker | Y / N | Smelter | Y / N | Mining |
| Y / N | Cotton Mill Worker | Y / N | Silica Dust | Y / N | Foundry |
| Y / N | Woodworker | Y / N | Sandblaster | Y / N | Ship Yards |
| Y / N | Farming | Y / N | Carpenter | Y / N | Pottery Worker |
| Y / N | Radiation | Y / N | Painter | Y / N | Talc Worker |
| Y / N | Railroad Worker | Y / N | Insulation Worker | Y / N | Asbestos Abatement Worker |
| Y / N | Textile Manufacturing | Y / N | Beryllium Worker | Y / N | Aluminum Worker |
| Y / N | Umatilla Army Depot Worker | Y / N | Plastic Worker | Y / N | Hanford Worker – Wash. State |
| | | | | Y / N | Insulation Product Manufacturing |

**Home Environment (circle):** water damage/flooding visible mold down pillows/comforters

**Tobacco: Are you a:** **Current cigarette smoker** **Former cigarette smoker** **Never smoker**

How many years have you/did you use smoke cigarettes? ________

If yes, how many cigarettes a day (average use)? ________

If you are no longer using tobacco, when did you quit? ________

**Do you now or have you ever used other tobacco products: Yes No If Yes, circle: cigars chew pipes**

**Describe** ______________________________________________

**Caffeine:** Caffeinated Coffee (8 oz) ____ Caffeinated Tea (8 oz) ____ Caffeinated Soft Drinks (12 oz) ____

**Alcohol:** Amount you have on **weekdays/work days**? _____ Per day on **weekends (non-work days)**? _____ per day

**Recreational Drugs:** Have you ever used **marijuana or any other drugs**? **Yes No** Describe ____________

Do you currently use **marijuana or take any other drugs**? **Yes No** Describe; ____________

**Have you ever used diet pills? Yes No describe:** ________ **History of blood transfusion? Yes No When:** ________

**Serve in the Armed Forces? Yes /No** ____________ **What are your hobbies?** ____________

**Where have you traveled in the past year?** ________________ **Do you use hot tubs? Yes No**

**Do you have any pets? Yes No If yes, what type?** ____________

**How is your home heated? Gas Electric Baseboard Forced Air Fireplace Woodstove** ________

**Exposure to Tuberculosis (Tb)? Yes No** ________

**Skin testing (Mantoux, PPD) for Tb? Yes No** ________ **Result:** ________

## FAMILY MEDICAL HISTORY – please indicate affected family member(s)

| | | |
|---|---|---|
| **Asthma** ________ | **Lung Cancer** ________ | **Heart Disease** ________ |
| **COPD/Emphysema** ________ | **Blood clots** ________ | **Other Lung Disease** ________ |
| **Sleep apnea** ________ | **Tuberculosis** ________ | ________ |

## REVIEW OF SYSTEMS

| | | | |
|---|---|---|---|
| **Respiratory**<br>☐ Shortness of breath<br>☐ Wheezing<br>☐ Cough, dry<br>☐ Cough, productive<br>☐ Coughing up blood<br>☐ Oxygen use | **Respiratory (cont')**<br>☐ Snoring<br>☐ Stop breathing during sleep<br>☐ Sleepiness<br>☐ Diagnosed with sleep apnea/past sleep testing | **Cardiovascular**<br>☐ Chest pain<br>☐ Murmurs/Valve problems<br>☐ Muscle pain w/ walking<br>☐ Leg swelling<br>☐ Hypertension<br>☐ Palpitations | **Neurological**<br>☐ Weakness<br>☐ Seizures<br>☐ Fainting<br>☐ Tremor<br>☐ Problem w/ balance/walking<br>☐ Numbness or neuropathy |
| **Eyes**<br>☐ Eye redness<br>☐ Blurry vision<br>☐ Dry eyes | **Ear, Nose**<br>☐ Hearing loss<br>☐ Broken nose<br>☐ Nose bleeds<br>☐ Nasal polyps<br>☐ Recurrent sinusitis | **Mouth, Throat**<br>☐ Mouth sores<br>☐ Speech problems<br>☐ Hoarseness<br>☐ Swallow difficulty<br>☐ Painful swallow | **Psychiatric**<br>☐ Depression<br>☐ Anxiety<br>☐ Drug Use or addiction<br>☐ Alcoholism |
| **Musculoskeletal**<br>☐ Aching muscles<br>☐ Low back pain<br>☐ Joint pains<br>☐ Joint swelling<br>☐ Joint redness | **Endocrine**<br>☐ Increased thirst<br>☐ Cold Intolerance<br>☐ Hot Flashes<br>Diabetes<br>Thyroid disease | **Genitourinary**<br>☐ Painful urination<br>☐ Blood in urine<br>☐ Urinary frequency<br>☐ Kidney stones | **Gastrointestinal**<br>☐ Acid Reflux/heartburn<br>☐ Abdominal pain<br>☐ Nausea or vomiting<br>☐ Liver disease or hepatitis<br>☐ Blood in stool |
| **Skin/Hair/Breast**<br>☐ Unexplained hair loss<br>☐ Unexplained Rashes<br>☐ Eczema<br>☐ New or changed spots | **Allergic/Immunologic**<br>☐ Seasonal Allergy<br>☐ Post nasal drip or hay fever<br>☐ Frequent Infections | **Heme/Lymphatic**<br>☐ Swollen lymph nodes<br>☐ Anemia<br>☐ Easy Bruising/Bleeding<br>☐ Blood Transfusions | |
| **Constitutional**<br>☐ Night sweats<br>☐ Fever<br>☐ Chills | **Constitutional (cont')**<br>☐ Weight loss, how much? ________ Over how long? _____months _____years<br>☐ Weight gain, how much? ________ Over how long? _____months _____years<br>☐ Loss of appetite ☐ Lack of energy | | |