Welcome to Santiam Pulmonary Clinic. In order to insure your best care, it is important that you take the time to complete this pulmonary patient medical history questionnaire thoroughly.

## Pulmonary Consultation – Patient History Form

Name ____________________________________________ Age_____ Date of Birth ___/___/____

Date: ___/___/____ Referring Physician: __________________ Primary Care Physician__________________

Why are you seeing a lung doctor?______________________________________________

______________________________________________________________________

How long have you had this problem? ___________________________________________

### Respiratory Assessment Questionnaire: (Please circle Y for Yes or N for No)

Y/N Unable to catch your breath at rest
Y/N Wheezing
Y/N Frequent sputum production
Y/N Chest pain or pressure
Y/N Night sweats
Y/N Excessive sleepiness or fatigue
Y/N Previous abnormal chest x-ray
Y/N Collapsed lung (Pneumothorax)
Y/N Shortness of breath with exertion
Y/N Recurrent cough
Y/N Coughing up blood
Y/N Inability to sleep laying flat
Y/N Recent voice change
Y/N Swollen legs
Y/N Oxygen in use or recommended. How much?________
What symptoms make you stop walking?_________________
How far can you walk without stopping?_________________

### Past Medical History/Procedures: (Please check off any illnesses or procedure you have had)

___ Rheumatic Fever
___ Scarlet Fever
___ Heart Attack
___ High Blood Pressure
___ Diabetes
___ Emphysema
___ Asthma
___ Malaria
___ Chronic/recurrent bronchitis
___ Bronchiectasis
___ Pneumonia
___ Allergies
___ Tuberculosis or exposure to
___ Macrodantin usage (also known as Macrobid or Nitrofurantoin)
___ Amiodarone usage (also known as Pacerone or Cordarone)
___ Hay Fever
___ Kidney Disease
___ Liver Disease
___ Gallbladder
___ Anemia
___ Whooping Cough
___ Chicken Pox
___ Cancer
___ Bronchoscopy or Lung Biopsy
___ Pulmonary Function Testing (e.g. spirometry)
___ Lung Surgery
___ Heart Surgery
___ Blood clot in your extremities or lung(s)

### Immunizations & Vaccines: (Please check all that you've had and list the year in which you had it.)

| | | (Year) | | | (Year) |
|---|---|---|---|---|---|
| ___ | Tetanus/booster | _____ | ___ | Chicken Pox | _____ |
| ___ | Hepatitis B | _____ | ___ | Influenza | _____ |
| ___ | Pneumococcal | _____ | ___ | MMR | _____ |
| ___ | Herpes Zoster | _____ (Shingles) | | | |

**When was your last TB skin test?** ________**was it** _____ **Positive** _____ **Negative**
Did you have a chest x-ray after the TB skin test? _____ Yes _____ No
*If yes, were the results normal?* _____ Yes _____ No

Name:______________________________ Date of Evaluation____/____/____

**Surgery:**

| Name of Surgery | Year | Surgeon | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

☐ If you need more room, check this box and add additional notes on page ( 5 )

**Hospitalizations for illness:**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

☐ If you need more room, check this box and add additional notes on page (5 )

**Medications:** Please list your current medications: (*include any Inhalers, Nebulizers and/or over- the- counter such as vitamins)*

| Medication | Strength | Frequency |
|---|---|---|
| | | |
| | | |
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| | | |

☐ If you need more room, check this box and add additional notes on page (5 )

**Allergies to Medications:**

| Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |

☐ If you need more room, check this box and add additional notes on page (5 )

## Family History:

| Family Member | Living | Deceased | Age/Age at Death | Health Problems or Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Spouse | | | | |
| Siblings | | | | |
| | | | | |
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| | | | | |

☐ If you need more room, check this box and add additional notes on page (5

Name:______________________________ Date of Evaluation____/____/____/

**Check any disease that a blood relative may have had:**

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Blood clotting disorders
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Emphysema
- ☐ Strokes
- ☐ Other *(please describe):*
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Factor V Leiden Mutation
- ☐ Alpha-1 Antitrypsin Deficiency
- ☐ Cystic Fibrosis

## Social History:

**Marital Status:** (Circle One)
Single / Married / Divorced / Widowed

**Children:**
Number of children: ____________
Any Medical Problems? ____________
______________________________

**Living Demographics:**
Where did you grow up? ____________
Where have you lived most of you life? ________
What is your level of education? ________

**Exercise:**
Do you exercise regularly? Y / N

**History of Alcohol Use:**
Do you consume alcohol? Y / N
If so, how many drinks per week? ________

**Describe Your Home:** *(Circle one).*
House / Apartment / Mobile Home / Other
Problems with water leaks, wet spots, black mold? Y / N
How is home heated? ____________

**Pets:**
Do you have pets in your home? Y / N
Cat(s) / Dog(s) / Bird (s) / Farm Animals

**History of Tobacco Use:**
Do you smoke cigarettes/cigars? Y / N
If so, how many per day? ____________
How many years have you smoked? ____________
If you used to smoke, how long ago did you quit? ________
Do you live with a smoker? ____________

**Caffeine Use:**
Do you consume caffeine? Y / N
If so, how many drinks per day? ____________

**Recreational Drug Use:**
Do you use recreational drugs? Y / N
If yes, what type and how often? ____________
Have you ever used I.V. drugs? Y / N

**Employment History:**
Are you working now? Y / N
Have you ever been exposed to asbestos, sand or dust at work? Y / N

Have you ever been exposed to radiation or strong fumes? Y / N
Shipyard work? Y / N
Electrician work? Y / N
Plumbing work? Y / N
What jobs have you done? ____________
______________________________
______________________________

## Occupational and Environmental Exposure History: (Please circle Y for Yes or N for No)

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

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

Name:______________________________________________ Date of Evaluation:_____________________

## Activities of Daily Living: (Are you experiencing any of the following – Circle Y for Yes and N for No?)

Y / N Difficulty with bathing, dressing or feeding yourself?
Y / N Difficulty with showering, vacuuming, or bed making?
Y / N Difficulty getting out of chairs or bed?
Y / N Decreased movement or strength in your arms or legs?
Y / N Have you fallen in the last month, or have balance problems?
Y / N Has it been more than 5 years since you obtained a new wheelchair?
Y / N Do you often choke on food, liquids or pills?
Y / N Do you have difficulty communicating your needs to others?
Y / N Decrease in the loudness of your voice or ability to speak clearly?

## Patient Medical/Legal Health Care Documents and Directives:

Y / N Do you have a Living Will or Advance Directive?
Y / N Do you have an Organ Donor Card designated on your Oregon Driver's license?
Y / N Do you have a Healthcare Power of Attorney?
Y / N Full Resuscitation
Y / N Do Not Resuscitate
Y / N No ventilator support
Y / N General Medical Care Only

**What are your general thoughts about end of life care?** ____________________________________

______________________________________________________________________

______________________________________________________________________

**Would you like a copy of our report to go to any other doctors?** *(Please List below)*
1.
2.
3.

**Please use this space to fill in any details from prior pages where you required extra room for documentation.**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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______________________________________________________________________

______________________________________________________________________