

# Pulmonary Patient Medical History Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician (if different): \_\_\_\_\_

Please describe your current medical problems.

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Please describe any previous medical problems and surgical procedures.

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Are you allergic to any medications?

No  Yes (List) \_\_\_\_\_

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Please list your current medications and doses.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever smoked cigarettes, cigars or pipe?  Yes  No

If yes, how many years have you/did you smoke? \_\_\_\_\_

If yes, how many cigarettes a day (average consumption)? \_\_\_\_\_

If yes, do you currently smoke? \_\_\_\_\_

If you are no longer smoking, when did you quit? \_\_\_\_\_

Do you drink alcohol?  Yes  No

If yes, Daily: \_\_\_\_\_ per day

Occasionally: \_\_\_\_\_ per month

Rarely: \_\_\_\_\_ per year

What is/was your occupation? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Have you traveled outside the country in the past year?  Yes  No

Do you have any pets, if so what type? \_\_\_\_\_

Do you exercise regularly, if yes what type of exercise do you do? \_\_\_\_\_

Please list any medical problems that may run in your family. \_\_\_\_\_

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

Pottery worker  Yes  No

Pipe coverer  Yes  No

Farmer  Yes  No

Talc worker  Yes  No

Carpenter  Yes  No

Woodworker  Yes  No

Mica worker  Yes  No

Painter  Yes  No

Smelter  Yes  No

Silica dust  Yes  No

Textile manufacturing

Insulation product manufacturing

Cotton mill worker  Yes  No

Insulation worker  Yes  No

Sandblaster  Yes  No

Beryllium worker  Yes  No

Aluminum worker  Yes  No

Plastic worker  Yes  No

Pulp mill worker  Yes  No

Railroad worker  Yes  No

Mining  Yes  No

Foundry  Yes  No

Yes  No

Yes  No

Please circle the symptoms or areas of your body that are bothering you.

<b>Neurological:</b>	Headache / Convulsions / Seizures / Fainting / A.D.D. / Stroke Other: _____	None
<b>Psychiatric:</b>	Depression / Anxiety / Stress / Excess worry / Drug/alcohol issues Other: _____	None
<b>Eyes:</b>	Visual problems / Blurry vision / Red eyes Other: _____	None
<b>Nose:</b>	Nasal allergies / Nose bleeds Other: _____	None
<b>Throat:</b>	Swallowing difficulty / Frequent sore throats / Speech problems Other: _____	None
<b>Mouth:</b>	Dental problems / Tongue problems / Canker sores Other: _____	None
<b>Neck:</b>	Swollen glands / Thyroid problems Other: _____	None
<b>Chest:</b>	Chest pain / Asthma / Shortness of breath / Cough / TB Other: _____	None
<b>Heart:</b>	Murmurs / Palpitations / Valve problems / Mitral valve prolapse Angina Other: _____	None
<b>Intestinal:</b>	Colitis / Ulcer gastritis / Barrett's esophagus / Polyps / Constipation Other: _____	None
<b>Urinary:</b>	Urinary problems / Urinary frequency / Burning / Kidney stones Other: _____	None
<b>Genital:</b>	Infections / Warts / Herpes / Impotence / Sexual difficulty Other: _____	None
<b>Upper Extremity:</b>	Pain in arm / Carpal Tunnel / Shoulder pain / Elbow pain / Wrist pain Other: _____	None
<b>Lower Extremity:</b>	Pain in legs / Knee pain / Hip pain / Ankle pain / Tingling Other: _____	None
<b>Spine:</b>	Low back pain / Neck pain / Mid back pain / Scoliosis / Sciatica Herniated disc Other: _____	None
<b>Systemic:</b>	Weight loss / Fever / Night sweats / Trouble sleeping / Loss of energy Arthritis Other: _____	None