PULMONARY CRITICAL CARE AND SLEEP SPECIALISTS, P.A

New Patient Health Questionnaire

Name:____
Last *First* *Middle*

MEDICAL HISTORY

How would you rate your current health condition?

( ) Very Good ( ) Good ( ) Average ( ) Poor ( ) Very Poor

Check any of the following health conditions that you have or have had in the past:

High Blood Pressure	○ Now ○ Past	Peptic Ulcers	○ Now ○ Past
Stroke	○ Now ○ Past	Acid Reflux (Heartburn)	○ Now ○ Past
Heart Disease or CHF	○ Now ○ Past	Kidney Disease	○ Now ○ Past
Heart Attack	○ Now ○ Past	Thyroid Disease	○ Now ○ Past
Angina	○ Now ○ Past	Arthritis	○ Now ○ Past
Emphysema or COPD	○ Now ○ Past	Back Pain	○ Now ○ Past
Asthma	○ Now ○ Past	Head Trauma	○ Now ○ Past
Tuberculosis	○ Now ○ Past	Severe Headaches	○ Now ○ Past
Nasal Allergies	○ Now ○ Past	Epilepsy (Seizures)	○ Now ○ Past
Hormonal Problem	○ Now ○ Past	Passing out spells (Fainting)	○ Now ○ Past
Urological Problem	○ Now ○ Past	Depression	○ Now ○ Past
Prostate Disease	○ Now ○ Past	Anxiety Disorder	○ Now ○ Past
Anemia	○ Now ○ Past	Problems with alcohol	○ Now ○ Past
Diabetes	○ Now ○ Past	Problems with drugs	○ Now ○ Past

Have you ever had a TB skin test? ☐ YES ☐ NO (If yes), ☐ Positive ☐ Negative
Date of last TB skin test (PPD)______________________
Have you ever been tested or diagnosed with HIV? ☐ YES ☐ NO (If yes, When?) ______________

Please list any hospitalizations you have had in the past:

Reason for hospitalization	Date

Smoking History

☐ Currently smoke ☐ Never have smoked ☐ Formerly smoked Quit date:___________

Packs per day______ Smoked for _____ years

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Patient's Name: ____

Please list any surgeries you have had in the past:

Type of surgery	Date

Have you ever worked with or been exposed to any of the following? ☐ No ☐ Yes (If yes, circle which apply):

☐ Asbestos ☐ Welding ☐ Coal Mining ☐ Metals Manufacturing ☐ Silica Mill ☐ Grain Dust Grinder

FAMILY HISTORY- Please check and list any family members with any of the following conditions:

☐ Diabetes ________________________________ ☐ Cancer ___________________________________
☐ Stroke __________________________________ ☐ Asthma __________________________________
☐ Heart Disease ____________________________ ☐ Tuberculosis ______________________________
☐ High Blood Pressure ______________________ ☐ Lung Disease ______________________________

IMMUNIZATIONS **Year of last shot or booster**

Influenza (flu) __________________________

Pneumovax (pneumonia shot) __________________________

Tetanus __________________________

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Patient's Name:____

Review of Symptoms:

GENERAL	**Yes**	**No**	**URINARY**	**Yes**	**No**
Fever			Increased frequency		
Weight Loss			Urgency		
Fatigue			Pain or burning with urination		
Night sweats					
			MUSCULOSKELETAL		
RESPIRATORY			Muscle stiffness		
Cough			Joint pain/arthritis		
Wheezing			Back pain		
Shortness of Breath					
Chest Tightness			**NEUROLOGICAL**		
Coughing blood			Weakness in arms or legs		
			History of seizures		
CARDIAC					
Irregular heart rhythm			**VASCULAR**		
Chest pain			Pains in legs while walking		
Wake up at night short of breath			Swelling of legs or ankles		
Heart palpitations					
EAR, NOSE AND THROAT			**EYES**		
Nose bleeds			Eye Irritation		
Earache			Blurred/Double Vision		
Ear infections					
Post nasal drip			**SLEEP**		
Hoarseness			Snoring		
Headaches			Excessive Daytime Sleepiness		
Seasonal Allergies			Fatigue		
			Choking during Sleep		
GASTROINTESTINAL			Stop Breathing during Sleep		
Gastric reflux			Restless Sleep		
Constipation			Wake Up Fresh in Morning		
Vomiting			Insomnia		
Abdominal Pain					
Diarrhea			**PSYCHIATRIC**		
			Anxiety		
SKIN			Depression		
Rashes					
Itching					
Hives					

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Patient's Name:____

CURRENT MEDICATIONS

Please list all medications (over the counter and prescription), vitamins and herbal supplements you have taken in the last **6 months**.

Name of drug/medication	Dose	# of pills	Taken for how long?	Taken for what problem?	Still taking?	
					Yes	No

Allergies:____

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