SALEM PULMONARY ASSOCIATES, P.C.

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Welcome to Salem Pulmonary Associates. 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
___ 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)
___ Macrodantin usage (also known as Macrobid or Nitrofurantoin)
___ Amiodarone usage (also known as Pacerone or Cordarone)

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

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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

☐ 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				

☐ 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	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

Name:_____ Date of Evaluation_____/_____/_____/

Review of Systems: (Please check off any symptom(s) that you are experiencing)

Constitutional:
____ Lack of energy
____ Weight gain
____ Weight loss
____ Fevers
____ Chills
____ Night sweats
____ Daytime sleepiness
____ Trouble sleeping
____ Weakness
____ Loud snoring
____ Breathing difficulty while sleeping (apnea)

Ophthalmologic:
____ Wears glasses/contacts
____ Watering/irritation of eyes
____ Cataracts
____ Glaucoma
____ Vision Changes

ENT:
____ Difficulty hearing
____ Earache
____ Buzzing or ringing in ears
____ Nasal stuffiness
____ Nose bleeds
____ Persistent hoarseness
____ Sore or bleeding gums
____ Sore tongue
____ Wears dentures or partials
____ Sinusitis

Respiratory:
____ Shortness of breath
____ Wheezing
____ Raises phlegm
____ Coughs up blood
____ Daily cough
____ Asthma
____ Emphysema
____ Recurrent bronchitis
____ Tuberculosis
____ Pneumonia
____ Fluid around lungs
____ Scarring of lungs

Cardiac:
____ Chest pain/angina
____ Irregular heartbeat/murmur
____ High blood pressure
____ Heart attack
____ Leg swelling/pain
____ Circulation problems

Gastrointestinal:
____ Poor appetite
____ Trouble swallowing
____ Painful swallowing
____ Heartburn
____ Stomach ulcer/pain
____ Indigestion
____ Constipation
____ Diarrhea
____ Nausea
____ Vomiting
____ Hemorrhoids
____ Black stools
____ Blood in stools
____ Jaundice
____ Liver problems
____ Pancrease problems
____ Gallstones
____ Vomiting blood
____ Hepatitis

Genitourinary:
____ Getting up more than once a night to urinate
____ Trouble starting stream
____ Trouble emptying bladder
____ Blood in urine
____ Venereal disease
____ Kidney or bladder stones
____ Impotence

Immune System:
____ Multiple infections
____ Immune deficiency
____ Seasonal allergies

Musculoskeletal:
____ Joint pain, swelling or redness
____ Arthritis
____ Back pain
____ Muscle pain
____ Gout
____ Osteoporosis
____ Phlebitis

Dermatologic:
____ Rash
____ Skin cancer
____ Skin infections
____ Acne
____ Nonhealing ulcer

Endocrine:
____ Diabetes
____ Thyroid disease
____ High cholesterol
____ Excessive thirst
____ Excessive hunger
____ Adrenal gland problems

Hematologic:
____ Easy bleeding or bruising
____ Anemia
____ Clotting disorder
____ Previous transfusions
____ Blood clots in legs
____ Blood cancer

Neurologic:
____ Stroke
____ Seizures
____ Paralysis
____ Numbness of hands
____ Numbness of feet
____ Memory loss
____ Loss of consciousness
____ Headaches
____ Balance problems
____ General weakness
____ Localized weakness

Psychiatric:
____ Hallucinations
____ Feeling depressed
____ Suicidal thoughts
____ Suicide attempt
____ Anxiety
____ Nervous or upset
____ Insomnia

Gynecologic: (Female Only)
____ Breast lumps, masses
____ Breast cancer
____ Recent mammogram
____ Recent Pap smear
____ Recent pelvic exam
____ Menopause
____ Hysterectomy
____ Hormone therapy
____ Birth control pills
____ Breathlessness with exertion

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 bedmaking?
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.

_____

_____

_____

_____

_____

_____

_____

_____

Name: _____Date of Evaluation____/____/____/

This Section For SPA Physician and Medical Staff Documentation

PHYSICAL EXAMINATION:

Gen'l Appear _____Wt. _____Ht _____HR _____BP(arm/position) _____RR_____

WNL N=Normal A=Abnormal D=Deferred	**Description of Abnormal Findings**
☐ (3) **Nose:** Mucosa _____ Turb ____ Septum_____ Sinuses _____	
☐ **Mouth:** Mucosa _____ Teeth_____ Gingiva ____	
☐ **Throat:** Palate ____ Tongue____ Tonsils_____ Post. pharynx ____	
……	……
☐ (3) **Neck:** Appear ____ Thyroid ____ Jugular vein _____	
……	……
☐ (5) **Resp:** Sym/Exp _____ Effort _____ Percuss'n _____ Palp'n_____ Auscult'n _____	
……	……
☐ (1) **Heart:** Rate _____ Rhythm_____ S_1/S_2 _____ Murmur_____ Rub _____ Gallop _____	
……	……
☐ (2) **Abdomen:** Appear _____ Tenderness _____ Masses _____ Scars _____ Spleen _____ Liver _____	
……	……
☐ (1) **PVS:** Appear ____ Pulses _____ Edema _____Carotid Art ___	
……	……
☐ (1) **Extr:** Clubbing ____ Cyanosis _____Ulcers ____ Tenderness ____	
……	……
☐ (1) **Skin:** Rash _____ Lesions _____ Ulcers _____ Bruising _____	
……	……
☐ (2) **MS:** Strength _____ Tone _____ Movements _____ Atrophy _____ Gait _____ Station _____	
……	……
☐ (2) **Neuropsych:** Orient'n _____ Affect _____	
……	……
☐ **Chest (Breasts):**	
……	……
☐ **GU:**	

Notes: _____

_____

_____

_____

_____

_____

_____

_____

Name: _____Date of Evaluation___ _/____/____/

PHYSICIAN MEDICAL DECISION MAKING: **(For Medical Personnel Use Only)**

Data Reviewed:

□ **Chest radiographs:**
- □ Office (date) _____ Dictated? □ Yes
- □ Outside (date) _____

□ **Chest CT Scan (date)** _____

□ **Awake oximetry (date)** _____

□ **Overnight oximetry** (date) _____
- □ Office (date) _____
- □ Outside (date) _____

□ **VQ Scan (date)** _____

□ **PET/SPECT Scan (date**) _____

□ **Bronchoscopy (date)** _____

□ **PSG/MSLT (date)** _____

□ **Blood Tests/Other (specify & date):**

_____ _____

_____ _____

□ **Pulmonary Function Tests**
- □ Spirometry
- □ Office (date) _____

□ **Lung Volumes**
- □ Office (date) _____
- □ Outside (date) _____

□ **Diffusing Capacity**
- □ Office (date) _____
- □ Outside (date) _____

□ **Methacholine Challenge Testing**
- □ Office (date) _____
- □ Outside (date) _____

□ **ABG (date)** _____

□ **Exercise Stress Testing (date)**____

□ **6 Minute Walk Test (date)**_____

□ **Echocardiogram (date)** _____

□ **Thoracentesis (date)** _____

IMPRESSION:

PLAN:

Name: _____Date of Evaluation____/____/____/

SPA CLINICIAN NOTES

Chief Complaint/History of Present Illness:

Past Medical History:

Past Surgical History:

Family History:

Social History:

Risk Factors:

Allergies:

Immunizations:

Medications: