OVERLAKE MEDICAL CLINICS PULMONOLOGY

Pulmonary Patient Medical History Questionnaire

Date: _____

Name: _____ DOB: _____

Referring Physician: _____

Primary Care Physician (if different): _____

Please describe your current medical problems.

_____

_____

_____

Please describe any previous medical problems and surgical procedures.

_____

_____

_____

_____

Are you allergic to any medications?

□ No □ Yes (List) _____

_____

Please list your current medications and dose.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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	Cotton mill worker	□ Yes □ No
Pipe coverer	□ Yes □ No	Insulation worker	□ Yes □ No
Farmer	□ Yes □ No	Sandblaster	□ Yes □ No
Talc worker	□ Yes □ No	Beryllium worker	□ Yes □ No
Carpenter	□ Yes □ No	Aluminum worker	□ Yes □ No
Woodworker	□ Yes □ No	Plastic worker	□ Yes □ No
Mica worker	□ Yes □ No	Pulp mill worker	□ Yes □ No
Painter	□ Yes □ No	Railroad worker	□ Yes □ No
Smelter	□ Yes □ No	Mining	□ Yes □ No
Silica dust	□ Yes □ No	Foundry	□ Yes □ No

Textile manufacturing □ Yes □ No

Insulation product manufacturing □ Yes □ No

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

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