MEMORIAL PULMONOLOGY

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Original Date:	_____/_____/_____
Dates Revised:	_____/_____/_____

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	☐ M ☐ F	**DOB** _____/_____/_____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Referring Doctor:	**Primary Care Doctor:**

PAST MEDICAL HISTORY

Childhood Illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Others
Adulthood Illness:	☐ Asthma ☐ Pneumonia ☐ Emphysema ☐ Bronchitis ☐ Pleurisy ☐ Tuberculosis ☐ Sinus Problems ☐ Stomach Problems ☐ Liver Illness ☐ Heart Illness ☐ Sleep Disturbances ☐ Arthritis ☐ Cancer
Immunizations and Dates:	☐ Pneumonia: ☐ Influenza: ☐ BCG : ☐ yes ☐ no (circle one) ☐ PPD (TB skin test) positive or negative

List Any Other Medical Problems That Doctors Have Diagnosed:

Have you ever had a blood or blood product transfusion? ☐ Yes ☐ No

Surgeries: (start from the most recent)

Year	Name or Reason

OCCUPATIONAL HISTORY

Have you ever worked in a: ☐ Mining ☐ Quarry ☐ Foundry ☐ Pottery ☐ Brick Plant ☐ Cotton Hemp Mill ☐ Manufacture of Glass, Abrasives or Ceramics ☐ Other Dusty Environment (Specify)

Have you ever been exposed to: ☐ Asbestos ☐ Organic Solvents ☐ Lead ☐ Other Heavy Metals ☐ Acids ☐ Plastics ☐ Other (Specify)

Allergies to Medications or Food: ☐ Yes ☐ No

Name the Medication or Food:	Type of Reaction You Had:

HEALTH HABITS

Exercise:	☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week or more for 30 minutes)
Diet:	Are you dieting? ..... ☐ Yes ☐ No If yes, are you on a physician prescribed medical diet? ..... ☐ Yes ☐ No What kind? _____
Alcohol:	Do you drink alcohol? ☐ Yes ☐ No If yes, what kind?_____ How many drinks per day/week? _____
Tobacco:	Have you ever used any form of tobacco? ..... ☐ Yes ☐ No ☐ Cigarettes - Pks/day_____ ☐ Pipe - #/day _____ ☐ Cigars - #/day _____ ☐ # of Years (total)_____ ☐ or When have you Quit _____
Drugs:	Do you currently use recreational or street drugs? ..... ☐ Yes ☐ No Have you ever given yourself street drugs with a needle? ..... ☐ Yes ☐ No
Personal Safety:	Do you live alone? ..... ☐ Yes ☐ No Do you have vision or hearing loss? ..... ☐ Yes ☐ No Do you have an Advance Directive and/or Living Will? ..... ☐ Yes ☐ No

FAMILY HEALTH HISTORY

		Age	Age at Death	Significant Health Problems or Cause of Death			Age	Age at Death if applies	Significant Health Problems or Cause of Death
Father					**Children**	☐ M ☐ F			
Mother						☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			
Brothers and Sisters	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F				**Grandparents (Mother's Side)**				
	☐ M ☐ F				*Grandfather*				
	☐ M ☐ F				*Grandmother*				

	☐ M ☐ F				Grandparents (Father's Side)			
	☐ M ☐ F				*Grandfather*			
	☐ M ☐ F				*Grandmother*			

SYMPTOMS

Cough:	Do you usually cough first thing in the morning? ..... ☐ Yes ☐ No Does your cough wake you up during the night? ..... ☐ Yes ☐ No Do you cough more on any particular day of the week? (Specify)..... ☐ Yes ☐ No Does your cough get worse in any particular body position? (Specify) ..... ☐ Yes ☐ No How long have you been coughing? (Specify) .....
Sputum:	Do you usually bring phlegm/mucus while coughing first thing in the morning? ..... ☐ Yes ☐ No Do you usually bring phlegm/mucus while coughing at other times? ..... ☐ Yes ☐ No If you bring phlegm/mucus, what color is it? (Specify) ..... How long have you had sputum production? (Specify) ..... Have you ever coughed up blood? ..... ☐ Yes ☐ No If YES, when was it the last time? Specify).....
Wheezing:	Does your breathing ever sound wheezy? ..... ☐ Yes ☐ No Have you ever had attacks of shortness of breath with wheezing? ..... ☐ Yes ☐ No Have you ever had feeling of tightness in your chest? ..... ☐ Yes ☐ No At what age did the wheezing first occur? (Specify) ..... How often do you experience wheezing? ☐ Daily ☐ Nightly ☐ Few times a week ☐ Few times a month Is it worse any particular day of the week? (Specify) .....
Breathlessness:	Do you usually get short of breath walking up stairs?..... ☐ Yes ☐ No Do you usually get short of breath walking on level ground? ..... ☐ Yes ☐ No Do you usually get short of breath at rest? ..... ☐ Yes ☐ No Do you wake up at night because of shortness of breath? ..... ☐ Yes ☐ No What do you think precipitate you shortness of breath? (Specify) ..... What do you think make you shortness of breath better? (Specify) ..... How long have you been feeling breathless? (Specify) ..... Have you ever been prescribed oxygen? ..... ☐ Yes ☐ No

OTHER PROBLEMS

Please check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Eyes: ☐ Vision loss ☐ Itching ☐ Discharges ☐ Other (Specify)	**CVS:** ☐ Palpitations ☐ Heart murmur ☐ Varicosities ☐ Other (Specify)	**GU:** ☐ Painful urination ☐ Blood in urine ☐ Difficulties voiding ☐ Other (Specify)
ENT: ☐ Hearing loss ☐ Nasal or ear itching ☐ Nasal or ear discharges ☐ Other (Specify)	**GI:** ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Any bleeding ☐ Other (Specify)	**Musculoskeletal:** ☐ Joint pain ☐ Joint swelling ☐ Muscle or back pain ☐ Other (Specify)

SLEEP HABITS

From your personal or your significant other experience:	Do you have trouble sleeping?	☐ Yes	☐ No
	Do you feel refreshed upon awakening?.....	☐ Yes	☐ No
	Do you experience morning headaches?	☐ Yes	☐ No
	Do you fall asleep while waiting in line?	☐ Yes	☐ No
	Did anybody tell you snore?	☐ Yes	☐ No
	Did anybody tell you choke or gasp for air at night?	☐ Yes	☐ No
	Do you have any other sleep problems?		

E-mail form Reset form

Reviewed, Anatoli Krasko, M.D.

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