Advanced Respiratory & Sleep Medicine

Pulmonary/Critical Care/Sleep Medicine/Internal Medicine

New Patient Medical Questionnaire

Full Legal Name		Date:	
Please also complete the NEW PATIENT FACESHEET FORM. All information provided on these forms is confidential.			
Social Security Number			
Date/Place of Birth			
Drivers License			

In your own words, please tell us why you are obtaining this medical evaluation.

Please tell us what your goals are for this visit.

Medical History:			
☐ *Allergies*	☐ *Heart Attack*	☐ *Thyroid Disease*	☐ *Low Blood Pressure*
☐ *Arthritis*	☐ *High Blood Pressure*	☐ *Dizziness*	☐ *Headaches*
☐ *Asthma*	☐ *Heat Failure*	☐ *Hemophilia(Bleeder)*	☐ *Ringing of the ears*
☐ *Alcoholism*	☐ *Heart Disease*	☐ *Stomach Ulcers*	☐ *Hernia*
☐ *Back Trouble*	☐ *Fainting*	☐ *Mental Problems*	☐ *Gout*
☐ *Bladder Trouble*	☐ *Black Outs*	☐ *Kidney Problems*	☐ *Heartburn/Reflux*
☐ *Cancer*	☐ *Prostate Problems*	☐ *Hearing Trouble*	☐ *Venereal Disease*
☐ *Seizures*	☐ *Pneumonia*	☐ *Depression*	☐ *Diabetes*
☐ *Eye Trouble*	☐ *Impotence*	☐ *Muscle Cramps*	☐ *Anxiety*
☐ *Claustrophobia*	☐ *Tuberculosis*	☐ *Emphysema*	☐ *Liver Problems*
☐ *Lupus*	☐ *Meningitis*	☐ *Cystic Fibrosis*	☐ *Lung Fibrosis*
☐ *Rheumatoid Arthritis*	☐ *COPD*	☐ *Bronchiectasis*	☐ *Sarcoid*
☐ *Hospitalizations*	☐ *Trauma*	☐ *Sepsis*	☐ *Pneumonia*
☐ *Urinary infections*	☐ *Skin infections*	☐ *Bleeding Problems*	☐
Others/Describe:			

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Surgical History: (please include approximate date)

☐ *Tonsillectomy/Adenoidectomy*	☐ *Bone/Joints*	☐ *Biopsies*	☐ *Gall Bladder*
☐ *Lung surgery*	☐ *Cosmetic*	☐ *Appendectomy*	☐ *Thyroidectomy*
☐ *Heart Surgery/Stents*	☐ *Dental*	☐ *Abdominal Surgery*	☐ *Splenectomy*
Others/Describe:			

Review of Systems/Symptoms. Do you experience any of the following:

General			
☐ *Weight loss or gain*	☐ *Fever or chills*	☐ *Weakness*	☐ *Trouble sleeping*
☐ *Fatigue*	☐ *Nightsweats*	☐ *Malaise*	☐ *Lethargic*
☐ *Unexplained falls*	☐ *Poor appetite*	☐	☐
Skin			
☐ *Rashes*	☐ *Lumps*	☐ *Itching*	☐ *Dryness*
☐ *Color changes*	☐ *Hair and nail changes*	☐	☐
Head, Eyes, Ears, Nose, Throat			
☐ *Headache*	☐ *Head injury*	☐ *Hay fever*	☐ *Stuffiness*
☐ *Decreased hearing*	☐ *Tinnitus*	☐ *Earache*	☐ *Ear discharge*
☐ *Nasal discharge*	☐ *Nose bleeds*	☐ *Sinus pain*	☐ *Itching*
Throat and mouth			
☐ *Condition of teeth*	☐ *Bleeding gums*	☐ *Dentures?*	☐ *Last dental exam*
☐ *Sore tongue*	☐ *Dry mouth*	☐ *Sore throats*	☐ *Hoarseness*
☐ *Itchy Throat*	☐	☐	☐
Eyes			
☐ *Blurred vision*	☐ *Double vision*	☐ *Glasses/contact lenses*	☐ *Last eye exam*
☐ *Pain*	☐ *Redness*	☐ *Flashing lights*	☐ *Glaucoma*
☐ *Cataracts*	☐ *Feels like a curtain being pulled down*	☐ *Blind spots*	☐ *Yellow eyes*
Neck			
☐ *lumps*	☐ *swollen glands*	☐ *goiter (large thyroid)*	☐ *pain/stiffness*
Breasts			
☐ *Lumps*	☐ *Pain*	☐ *Discharge*	☐ *Self breast exams?*
☐ *Nursing a child?*	☐	☐	☐
Gastrointestinal			
☐ *Change in bowel habits*	☐ *Blood in stool*	☐ *Dark tarry stools*	☐ *Constipation*
☐ *Trouble swallowing*	☐ *Heartburn*	☐ *Loss of appetite*	☐ *Nausea*
☐ *Diarrhea*	☐ *Abdominal pain*	☐ *Jaundice*	☐ *Swallow pain*
Respiratory			
☐ *Cough*	☐ *Sputum color and amount*	☐ *Coughing blood*	☐ *Shortness of breath*

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☐ *Wheezing*	☐ *Painful breathing*	☐ *Exposure to tuberculosis*	☐ *Exercise intolerance*
Allergic/Immunologic			
☐ *Allergies*	☐ *Rash*	☐ *Sneezing*	☐ *Watery eyes*
☐ *Nasal drip*	☐ *Food allergy*	☐ *Dye allergy*	☐ *Pollen allergy*
☐ *Drug allergy*	☐ *Prior testing*	☐	☐
Cardiovascular			
☐ *Chest pain or tightness*	☐ *Palpitations*	☐ *Edema*	☐ *Orthopnea*
☐ *Awaking with shortness of breath*	☐ *Faintness*	☐	☐
Urinary			
☐ *Frequency of urination*	☐ *Nighttime urination*	☐ *Urgency*	☐ *Burning or pain*
☐ *Hematuria(blood)*	☐ *Infections*	☐ *Kidney stones*	☐ *Incontinence*
☐ *Hesitancy*	☐ *Decreased stream*	☐ *Dribbling*	☐
Male Genital			
☐ *Hernia*	☐ *Penile discharge*	☐ *Sores*	☐ *Testicular mass or pain*
☐ *Erectile Dysfunction*	☐ *Condom use*	☐ *STDs*	☐
Female Genital			
☐ *Periods*	☐ *Abortions*	☐ *Dysmenorrhea*	☐ *Pregnancies*
☐ *Vaginal discharge, itching or rashes*	☐ *STDs*	☐ *Birth Control*	☐
Vascular			
☐ *Claudication*	☐ *Leg cramps*	☐ *Varicose veins*	☐ *Blood clots*
Musculoskeletal			
☐ *Muscle or joint pains*	☐ *Stiffness*	☐ *Gout*	☐ *Back pain*
☐ *Swelling of joints*	☐ *Timing of symptoms*	☐ *Trauma*	☐
Neurologic			
☐ *Dizziness, lightheadedness*	☐ *Fainting*	☐ *Seizures*	☐ *Weakness, paralysis*
☐ *Numbness*	☐ *Tingling*	☐ *Tremor*	☐
Hematologic			
☐ *Easy bruising*	☐ *Easy bleeding*	☐ *Anemia*	☐ *Blood Clots*
☐ *Transfusion history*	☐	☐	☐
Endocrine			
☐ *Heat or cold intolerance*	☐ *Excessive sweating*	☐ *Polyuria*	☐ *Polydypsia*
☐ *Change in glove or shoe size*	☐	☐	☐
Psychiatric			
☐ *Nervousness*	☐ *Depressed mood*	☐ *Memory loss*	☐ *Stress*
☐ *Disturbing thoughts*	☐	☐	☐
Sleep			
☐ *Witnessed pauses in breathing*	☐ *Snoring*	☐ *Choking sensation*	☐ *Bedwetting*
☐ *Frequent urination*	☐ *Pain*	☐ *Restless sleep*	☐ *Arm/leg cramps*
☐ *Crawling sensation on legs*	☐ *Leg kicking*	☐ *Nightmares*	☐ *Difficulty falling asleep*
☐ *Difficulty staying asleep*	☐ *Daytime naps*	☐ *Daytime sleepiness*	☐ *Daytime fatigue*

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☐ *Use of sleep aids*	☐ *Caffeinated drinks*	☐ *Sleepy while driving*	☐
Other Symptoms:	☐	☐	☐
☐	☐	☐	☐

For patients undergoing Sleep Evaluation, complete these questions:				
How much weight have you gained in last 5 years?				
Do you snore?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Have you been told that you stop snoring?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you wake up gasping or choking?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you experience aching/twitching/ crawling sensation in legs at bedtime?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you experience pain/discomfort during sleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do headaches awaken you?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you have racing thoughts at bedtime?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you feel anxious about sleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do others complain about your sleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you have to wake up to go to the bathroom?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you have to wake up to attend to children or something else?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Is your sleep disturbed by anything in your environment?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you talk/yell during sleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you walk/run while asleep?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Have you fallen out of bed?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Experienced bedwetting?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Nightmares?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Have you been told that you acted out a dream?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Experienced teeth grinding?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
How many hours do you sleep/night(average)?				
How many times do you wake up?				
How long does it take to fall asleep?				
What time us usually bedtime?				
What time do you start your morning?				
Are you sluggish when getting out of bed?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Are you sleepy/tired during day?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you have difficulty staying awake while driving?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
Do you nap?	☐ *Yes*	☐ *No*	☐ *Sometimes*	
How many, if any, caffeinated drinks/day? (tea, soda, coffee)	☐ *Tea*	☐ *Soda*	☐ *Coffee*	☐ *Other*
Others symptoms/Describe:				

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Medications: (please list active and prior non-active 3 month history of medications, herbs, supplements)

Medication	Dose	Frequency	Reason

Please list all active and prior non-active nasal inhalers and bronchodilators below. *(ie flonase, nasonex, advair, xopenex, nebulizers)*

Any use of the following in your lifetime?

☐ *Fen-phen or weight loss drugs*	☐ *Methotrexate*	☐ *Autoimmune medications (ie plaquinal, cytoxan)*
☐ *Amiodarone*	☐ *Steroids (ie prednisone, solucortef)*	☐ *Cancer medications (ie rituxan, 5FU)*

Recreational Drugs?

☐ *Marijuana*	☐ *Cocaine*	☐ *Heroin*	☐ *PCP*
☐ *Ecstasy*	☐ *Anabolic steroids*	☐ *Other:*	

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Allergies:	
Medication	Reaction
Non-Medications (ie animals, trees,etc)	Reaction

Inhalational exposures:		
Have you ever been exposed to the following for more than 3 months?		
☐ *Asbestos*	☐ *Brake pads*	☐ *Coal mining*
☐ *Heavy metal mining*	☐ *Lead*	☐ *Explosives/fire*
☐ *Warfare chemicals*	☐ *Gasoline*	☐ *Silica*
☐ *Glass/fiberglass*	☐ *Pesticides*	☐ *Other:*
☐ *Other:*	☐ *Pets (ie dog, cat, bird)*	☐

Smoking exposure:		
Have you ever smoked? (if yes then complete smoking history)	☐ *Yes*	☐ *No*
Please estimate how many years you smoked:		
Please estimate how many packs per day you smoked:		
If you quit, when did you quit?		
Did you ever quit and then relapse to smoking?	☐ *Yes*	☐ *No*
How have you tried to quit smoking? (ie medications, will-power).		
Have you had second hand smoking exposure?	☐ *Yes*	☐ *No*
Have you smoked anything else? Please describe.		
Alcohol Use:		
Do you drink alcoholic beverages routinely? If so, what do you drink and how many drinks per day?		
Has anyone said that you have a problem with drinking?	☐ *Yes*	☐ *No*
Did you consuming alcoholic drinks?	☐ *Yes*	☐ *No*

Immunizations:	
Pneumovax	*Date given:*
Influenza (flu-vax)	*Date given:*
Diphtheria/Pertussis/Tetanus(DPT)	*Date given:*

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Hepatitis A	*Date given:*
Hepatitis B	*Date given:*
BCG	*Date given:*
PPD testing	*Date given:*

Family Medical History: (parents, grandparents, siblings)			
☐ *Allergies*	☐ *Heart Attack*	☐ *Thyroid Disease*	☐ *Urinary infections*
☐ *Arthritis*	☐ *High Blood Pressure*	☐ *Diabetes*	☐ *Skin infections*
☐ *Asthma*	☐ *Low Blood Pressure*	☐ *Hemophilia(Bleeder)*	☐ *Liver Problems*
☐ *Alcoholism*	☐ *Heart Disease*	☐ *Bleeding Problems*	☐ *Sarcoid*
☐ *Cancer*	☐ *COPD*	☐ *Lung Fibrosis*	☐ *Bronchiectasis*
☐ *Lupus*	☐ *Emphysema*	☐ *Kidney Problems*	☐ *Sleep apnea*
☐ *Rheumatoid Arthritis*	☐ *Cystic Fibrosis*	☐ *GI Problems*	☐ *Insomnia*
☐ *Other disorders:*			

This concludes the New Patient Medical Questionnaire. This information is confidential.
The New Patient Facesheet Form must also be completed before the 1st appointment.

Other forms that may need to be completed:

1. HIPAA Authorization Form. Allows release of information to other providers.
2. Release of Medical Information Form. Allows your provider to discuss confidential medical information with named persons.
3. Epworth Sleepiness Scale Form. Must be completed by sleep evaluation patients.
4. Bed Partner Questionnaire. If applicable, completed for those undergoing sleep disorder evaluation.