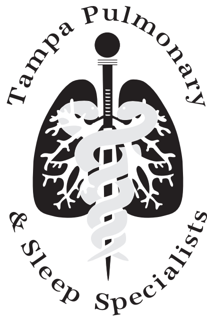

PULMONARY DISEASE QUESTIONNAIRE

Name: ____

Address: ____

____

Phone: __________________ DOB: __________________ SSN: __________________

Race: ________________ Sex: ________________ Weight: __________ Height: __________

Past Medical History:

Have you ever had or been told you had any of the following (If YES, please check off box)

Childhood Illnesses

- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Allergies

Adult Illnesses

- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Hepatitis/Jaundice
- ☐ Cirrhosis
- ☐ Colitis
- ☐ OSA - Sleep Apnea
- ☐ DVT/PE (Blood Clots)
- ☐ Pulmonary Hypertension
- ☐ Stroke or Paralysis
- ☐ Interstitial Lung Disease
- ☐ Heart Failure
- ☐ Diabetes (sugar)
- ☐ Arthritis
- ☐ Cancer

  Type ____________________

  Diagnosed Year: ____________

  Treatment

  - ☐ 1 - Radiation
  - ☐ 2 - Chemotherapy
  - ☐ 3 - Immunotherapy
- ☐ Anemia (low blood)
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Pneumonia
- ☐ Pleurisy (chest pains)
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Heart Disease
- ☐ Covid

Hospitalizations:

Have you ever been hospitalized?: ☐ Yes ☐ No

If YES, please list hospitalizations from first to last, giving the date and reason.

Please include medical illnesses (heart disease, kidney disease, depression, nervous breakdown, etc.), especially any hospitalizations/surgeries regarding the chest, lungs or heart disorders.

1. Year ________ Reason: ______________________________
2. Year ________ Reason: ______________________________
3. Year ________ Reason: ______________________________
4. Year ________ Reason: ______________________________
5. Year ________ Reason: ______________________________
6. Year ________ Reason: ______________________________
7. Year ________ Reason: ______________________________
8. Year ________ Reason: ______________________________

Surgeries:

Have you had a major surgery?: ☐ Yes ☐ No

If YES, please list hospitalizations from first to last, giving the date and reason.

Please include medical illnesses (heart disease, kidney disease, depression, nervous breakdown, etc.), especially any hospitalizations/surgeries regarding the chest, lungs or heart disorders.

1. Year ________ Reason: ______________________________
2. Year ________ Reason: ______________________________
3. Year ________ Reason: ______________________________
4. Year ________ Reason: ______________________________
5. Year ________ Reason: ______________________________
6. Year ________ Reason: ______________________________
7. Year ________ Reason: ______________________________
8. Year ________ Reason: ______________________________

Transfusions:

Have you ever received a blood transfusion?: ☐ Yes ☐ No

If YES, state the reason for the transfusion: ______________________________

Vaccinations:

If you have had any of the following, check and if possible give the date of the last vaccination or booster:

☐ Influenza (Flu) 20_____ ☐ Pneumococcal (Pneumonia) 20_____

☐ Covid 20_____ ☐ RSV Vaccine 20_____

☐ Other ______________________________

Diagnostic / Images:

CT Chest (CAT scan) Date: __________ Location: ______________________________

Chest X-Ray Date: __________ Location: ______________________________

Pulmonary Function Tests Date: __________ Location: ______________________________

Allergy Testing Date: __________ Location: ______________________________

Medications:

Please list below **ALL** medications you now take or have taken in the past 6 months. Please include aspirin, laxatives, nerve pills, birth control, vitamins, sleeping pills, etc.; whether they are prescription drugs or not.

Name (if known)	**Reason Taken**	**How Often** *If daily, how many/day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies:

Are you allergic to any medication or do you have any other allergies?: ☐ Yes ☐ No

If YES, please list the agent to which you are allergic and state the type of reaction you experienced.

Medication	Date	Reaction

Other	Date	Reaction

Cough: ☐ Yes ☐ No / **Productive**: ☐ Yes ☐ No / ☐ **Cough Up Blood** ☐ Yes ☐ No

Wheezing: ☐ Yes ☐ No

Shortness of Breath: ☐ Yes ☐ No / **At Rest:** ☐ Yes ☐ No / **With Activity:** ☐ Yes ☐ No

Chest Illness:

1. During the past 3 years have you had chest colds, bronchitis, or pneumonia?

   ☐ No, None ☐ Yes, 2 or 3 bouts ☐ Yes, more than 3 bouts

2. During the past 3 years, have any of these kept you off work or in bed for as long as a week?

   ☐ No ☐ Yes

3. When was your last cold? ______________________________

Tobacco Smoking:

1. Have you ever smoked tobacco / marijuana / vaping? ☐ No ☐ Yes

   If NO, skip down to ALCOHOL

2. Have you ever smoked cigarettes? ☐ No ☐ Yes
3. During your total years of cigarette smoking, what is the average number of packs of cigarettes that you smoked each day? _______
4. How many total years have you smoked?________
5. Have you stopped smoking? ☐ No ☐ Yes

   If YES, how long has it been since you stopped smoking?

   a. ________ months

   b. ________ years

6. Have you ever smoked cigars regularly? ☐ No ☐ Yes

   a. How many years?______________________

   b. How many cigars per day?_______________

   c. Do you still smoke cigars?_______________

   d. Do you or did you inhale? _______________

7. Have you had a Lung Cancer Screening CT Scan? ☐ No ☐ Yes

   If YES, Date:__________________ Location: ____

Alcohol:

Have you ever used alcoholic beverages? ☐ No ☐ Yes

If YES, check below:

- ☐ None for ______ years
- ☐ Presently
- ☐ Social only
- ☐ Daily
- ☐ To excess on occasion

Hobby and Leisure History:

Do you have contact with animals in your home? ☐ No ☐ Yes

- ☐ Birds
- ☐ Dogs
- ☐ Cats
- ☐ Others____

Do you have hobbies in which you may inhale fumes or dust? ☐ No ☐ Yes

If YES, please give details: ____

____

____

Occupation History:

Please list below all previous occupations from year first job to your current job:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Environmental Exposure History:

Please mark any of the following occupations that you have worked at and indicate the length of time you worked there:

- ☐ Asbestos ____________/________ (Months / Years)
- ☐ In a foundry ____________/________ (Months / Years)
- ☐ In a coal mine ____________/________ (Months / Years)
- ☐ In any other mine ____________/________ (Months / Years)

  State ____________ Type________________________

- ☐ In a quarry ____________/________ (Months / Years)
- ☐ In a pottery ____________/________ (Months / Years)
- ☐ In a cotton, flax, or hemp mill ____________/________ (Months / Years)
- ☐ In asbestos, milling, processing, painting spraying ____________/________ (Months / Years)
- ☐ As a tunnel worker ____________/________ (Months / Years)
- ☐ As a sandblaster ____________/________ (Months / Years)
- ☐ As a rock cutter ____________/________ (Months / Years)
- ☐ In manufacturing beryllium ____________/________ (Months / Years)
- ☐ In manufacturing ceramics, glass or abrasives ____________/________ (Months / Years)
- ☐ In any other job with exposure to dust, gas, or fumes ____________/________ (Months / Years)

Describe the job: ____

____

____

Family History:

Father:

Please check and describe where appropriate:

☐ Living Age:__________ Illness ____

☐ Deceased Age:__________ Cause ____

Mother:

☐ Living Age:__________ Illness ____

☐ Deceased Age at death: _____ Cause ____

Brothers and Sisters:

☐ Living Age:__________ Illness ____

☐ Deceased Age:__________ Cause ____

☐ Living Age:__________ Illness ____

☐ Deceased Age:__________ Cause ____

☐ Living Age:__________ Illness ____

☐ Deceased Age:__________ Cause ____

☐ Living Age:__________ Illness ____

☐ Deceased Age:__________ Cause ____

☐ Living Age:__________ Illness ____

☐ Deceased Age:__________ Cause ____