PULMONARY CONSULTANTS OF OCALA, PLLC
Pulmonary, Critical Care & Sleep Medicine

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PATIENT QUESTIONNAIRE

First:		MI: LAST:	
DOB:	Sex:	Marital Status:	Children:
Address:			Birth Place:
City		State:	Zip:
Home Phone#:		Cell Phone#:	
Primary Care Physician:		Telephone#:	
Other Physician(s):		Telephone#:	

Past Personal History (include date of diagnosis):

Cardiac:

- ☐ Heart attack
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Valve disease
- ☐ High blood pressure
- ☐ Other

Respiratory:

- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Pulmonary fibrosis
- ☐ Pulmonary hypertension
- ☐ Pneumonia
- ☐ Allergic rhinitis
- ☐ Obstructive sleep apnea
- ☐ Lung nodules/masses
- ☐ Pulmonary embolism
- ☐ Deep venous thrombosis
- ☐ Tuberculosis
- ☐ Lung cancer
- ☐ Pleural effusions
- ☐ Chronic sinusitis
- ☐ Other

Last tuberculosis skin test (PPD): Date: _____ ☐ Positive ☐ Negative

Hematologic:

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Low Platelets
- ☐ Leukemia

Cancer (Please indicate type, treatment and dates):

Type:	Treatment:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Gastrointestinal:

- ☐ Gastroesophageal reflux disease
- ☐ Peptic ulcer disease
- ☐ Colitis
- ☐ GI Bleed (upper or lower)
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Chronic diarrhea
- ☐ Hemorrhoids
- ☐ Other

Genitourinary:

- ☐ Renal failure
- ☐ Hemodialysis or peritoneal dialysis
- ☐ Urinary tract infections
- ☐ Kidney stones
- ☐ Kidney transplant
- ☐ Enlarged prostate
- ☐ Other

Endocrine:

- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ High cholesterol or triglycerides
- ☐ Adrenal insufficiency
- ☐ Diabetes mellitus
- ☐ Other

Neurologic:

- ☐ Stroke
- ☐ Transient ischemic attack
- ☐ Seizures
- ☐ Myasthenia gravis
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Multiple sclerosis
- ☐ Other

Rheumatologic:

- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Lupus
- ☐ Scleroderma
- ☐ Fibromyalgia
- ☐ Ankylosing spondylitis

Infections:

- ☐ HIV/AIDS
- ☐ Sepsis
- ☐ Rheumatic fever
- ☐ Fungal infections
- ☐ Parasitic infections
- ☐ Other

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Other

Skin:

- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Burns (major)
- ☐ Skin ulcers
- ☐ Nonhealing wounds
- ☐ Other

Eyes:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Retina detachment
- ☐ Other

Surgical History: (Please indicate type and dates)

Type:	Date:
_____	_____
_____	_____
_____	_____

Family History:

Father ☐ Living ☐ Deceased Cause of death _____
Mother ☐ Living ☐ Deceased Cause of death _____
Brothers
Sisters
Children

Occupational Exposure History:

☐ Asbestos	☐ Wood	☐ Marble
☐ Welding	☐ Masonry	☐ Silica
☐ Mining	☐ Construction/industrial dust	☐ Mold
☐ Chemicals _____		

Social History:

Tobacco: Do you currently smoke: ☐ Yes ☐ No

If yes, how much do you smoke, packs per day? _____

Did you ever smoke: ☐ Yes ☐ No

If yes, how much did you smoke, packs per day? _____ How long did you smoke? _____

Have you ever tried to quit? _____

Alcohol: ☐ Yes ☐ No If yes, when: _____ How much do you drink? _____

Other substances: _____

Work History:

Retired: ☐ Yes ☐ No If yes, when: _____

Current or former occupation: _____

Oxygen Use:

☐ Yes ☐ No If yes, how long have you been using oxygen? _____

When do you use oxygen, check appropriate box(es)

☐ Day ☐ Night ☐ As needed only

CPAP/BIPAP Use:

☐ Yes ☐ No

If yes, do you use CPAP with oxygen? ☐ Yes ☐ No

When and where was your sleep study done? _____

Allergies:

☐ Yes ☐ No If yes, list: _____

Medications:

Other pertinent medical information you need to provide: