Prana Health
Ad Vitam - For Life

# PULMONARY QUESTIONNAIRE

**Name: _____ Date: _____**

**Date of Birth: _____ Referring Physician: _____**

**Chief Complaint:**
**□Shortness of breath □ Cough □ Chest Pain □ Pulmonary Hypertension**
**□Lung mass □ COPD □ Asthma □ Pulmonary Fibrosis**
**□Abnormal Chest X-ray of CT scan**
**□Other (Please describe):_____**

## HISTORY

**How long have you had a pulmonary problem? _____**
**Have you had a prior Chest X-ray or CHEST CT Scan? □No □ Yes When? _____ Where? _____**
**Have you had a prior Pulmonary Function Test? □No □ Yes When? _____ Where? _____**

## SYMPTOMS

**Do you have**
**□ shortness of breath □No □ Yes**
**□ cough □No □ Yes (if, yes, do you bring up any phlegm □No □ Yes, or cough up blood □No □ Yes )**
**□ wheezing □ chest pain □ racing of heart □ dizzy spells □ swelling in the legs □ fever □ night sweats**

**Your symptoms are: □Mild □Moderate □Severe**
**Your symptoms are: □ worsening □ stable □ improving**
**Your symptoms are worsened by □ exertion □ lying down □ seasonal changes □ at night**
**□ other____**

**Do you snore? □No □ Yes**

**Has anyone told you that you stop breathing while asleep? □No □Yes**

**Check all those that apply:**

**□ History of pulmonary embolism □ Weight loss □Tuberculosis □ Cancer**
**□ Coughing up blood □ Use oxygen □Congestive heart failure □ Asthma**
**□ Sarcoidosis □ Pulmonary fibrosis □ Nasal Allergies □ Bronchitis**
**□ Use CPAP**

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**EPWORTH SLEEPINESS SCALE**

**How likely are you to DOZE OFF or FALL ASLEEP in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times (within the last 6 months or last year).**

**0 = Would NEVER doze**
**1= SLIGHT chance of dozing**
**2 = MODERATE chance of dozing**
**3 = HIGH chance of dozing**

| Situation | Chance of Dosing (circle one) | | | |
|---|---|---|---|---|
| Sitting and reading…….. | 0 | 1 | 2 | 3 |
| Sitting, inactive in a public place…… | 0 | 1 | 2 | 3 |
| Watching television…… | 0 | 1 | 2 | 3 |
| As a passenger in a car without a break…….. | 0 | 1 | 2 | 3 |
| Lying down in the afternoon when circumstances permit…….. | 0 | 1 | 2 | 3 |
| Sitting and talking to someone…… | 0 | 1 | 2 | 3 |
| Sitting after lunch without alcohol…….. | 0 | 1 | 2 | 3 |
| In a car, while stopped for a few minutes in traffic…… | 0 | 1 | 2 | 3 |

**TOTAL _____**

**PAST MEDICAL HISTORY**
**Medical illness: □Hypertension (high blood pressure) □Heart attack/Angina □Heart Failure □ Rheumatoid arthritis □ Lupus, □Nasal Congestion □ Depression □Stroke □Allergies □ Atrial Fibrillation □COPD □Allergic rhinitis □ Iron Deficiency**
**□Acid reflux (GERD) □ TB □Blood clots in legs /lungs □ sarcoidosis □ cancer**

**SURGICAL HISTORY: □Adeno-tonsillectomy □ Heart Bypass □ stent placement Pacemaker implantation □ C-section □ Sinus surgery**

**FAMILY HISTORY: Does anyone in your family have or has ever had any of the following (Please check all that apply): □TB □Lung Cancer □ COPD □Asthma □ blood clots □ pulmonary fibrosis □Any other major lung disease: _____**

**SOCIAL HISTORY**

**OCCUPATION:_____MARITAL STATUS:_____**
**Are you a current or former smoker? □No □Yes**
**Do you drink alcohol? □No □Yes If yes, how much?_____**

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**Have you ever been exposed to the following in the past?**

**Asbestos □No □Yes Amiodarone □No □Yes Radiation □No □Yes Methotrexate □No □Yes**
**Silica Dust □No □Yes Industrial chemicals □No □Yes TB (Tuberculosis) □No □Yes**
**Patient Name: _____**

**<u>ALLERGIES:</u> Please list all, if any allergies with the type of reaction:**

_____ _____
_____ _____

**REVIEW OF SYSTEMS: (Please check all that apply to you):**

**General: □Weight Loss □Weight Gain □Night Sweats**
**Eyes: □ Decreased vision □ Glaucoma □ Wears Glasses**
**Cardiovascular: □Chest pain □Palpitation/ irregular heart beat □Murmur □Leg Swelling**
**Respiratory: □Chronic Cough □Shortness of breath □Wheezing/Asthma**
**Gastrointestinal: □Constipation □Hepatitis □Blood in the stools (ulcers, polyps, etc)**
**Genitourinary: □Bedwetting □Frequent urination at night □Decreased Libido**
**Musculoskeletal: □ Joint Pains □ Gout**
**Skin: □ Easily bruised □ Rash**
**Neurological: □Weakness □ Numbness and Tingling □ Frequent headaches □Neuropathy**
**Psychiatric: □Anxiety □Depression**
**Endocrine: □Thyroid disease □ Diabetes □ Low Testosterone**
**Hematopoietic: □Anemia (low blood count) □ Bleeding tendency**
**Ears: □Decreased hearing □Ear Infections □Ringing in the ears**
**Allergic Immunologic: □Seasonal allergies □Contact dermatitis with Neoprene □ Rash with electrode gel**

**<u>WOMEN:</u> □Irregular periods □Pregnant □Using contraceptives**

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