Prana Health
Ad Vitam - For Life

ADULT 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 □ Nasal Congestion/discharge/bleeding □ Nasal blockage

□ Facial Pain/fullness/pressure □ Loss of sense of smell

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Patient's name _____ DOB_____

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?_____
Do you drink caffeinated beverage? □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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Patient's name _____ **DOB**_____

DEPRESSION SCREEN

1. **Over the *last 2 weeks,* how often have you been bothered by any of the following problems?**

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching tv.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

ADD COLUMNS: _____ + _____ + _____ + _____

TOTAL: _____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the las 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the day	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	_____	_____	_____	_____

Total Score =_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all_____
Somewhat difficult_____
Very difficult_____
Extremely difficult_____