**Pulmonary & Interventional**
**Critical Care and Sleep Medicine.**
*Pulmonics Plus Pllc (PPP)*

**New Patient**
**Pre Clinic Questionnaire**

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Patient Name_____ DOB:_____Email:_____ @_____

Home Phone:_____ Cell Phone:_____Other (next of kin) _____

## MEDICAL GENERAL

Family Physcian_____Other specialist (eg cardiologist)_____

Please list respiratory or pulmonary issues you like to address: _____

_____ (for sleep related issues ask for additional questionnaire)

❑ NO ❑ YES Do you Shortness of breath (if yes specify): _____ _____

If yes also: How much can you walk _____( In terms of 1,2 or 3 blocks etc)

❑ NO ❑ YES Shortness of breath on lying flat. How many pillows you use to sleep _____

❑ NO ❑ YES Leg or Ankle Swelling Baseline weights in pounds_____lbs

❑ NO ❑ YES Do you wheeze (if yes specify- circle): Morning, Evening, All day, After food, Posterior nasal drip

❑ NO ❑ YES Do you have a Cough (if yes specify**- circle**): Dry, Productive, Blood, After food, Nasal drip

❑ NO ❑ YES Does something Trigger above symptoms (if yes specify):_____

Write in the type and year of any operation/surgery you have had:_____

_____

_____

_____(use next page if needed)

List Medical illnesses you have (**circle** where appropriate):_____

| | | |
|---|---|---|
| ❑ high BP / Cholesterol | ❑ Afib/ Lung or Leg Clot | ❑ Diabetes/ Thyroid: |
| ❑ Pacemaker/ Stent/ MI | ❑ COPD/ Asthma | ❑ Liver issues:_____ |
| ❑ Kidney issue_____ | ❑ Heart burn/ stomach | ❑ Seizure/Stroke/TIA |
| ❑ Cancer: _____ | | ❑ Anxiety/Depression |
| ❑ Sleep apnea | ❑ Pulm Hypertension | ❑ Lung fibrosis/ ILD or IPF |

Other Medical Issues (please specify):

_____

_____

_____(use end of page if needed)

Current medications (dose and frequency):_____

_____

_____

_____ (use end of page if needed)

Any Allergies to medications? (describe reaction): _____

Allergies to the following (please **circle**): Pollen, Grass, Mold, Dust, Hay, Weather, Perfumes, Animals specify_____

Do you have any Pets Home (if yes specify): _____

Alcohol, tobacco or drug use? Please specify how much, how often and for how many years:_____

_____

_____

Family medical history (specify if any one had Asthma/sarcoidosis etc) :_____

Father:_____ Mother:_____

What is your current Occupation (please list past occupation too):_____

Any past exposure to toxic or industrial agents (dust / chemicals etc ) ? Please specify: _____

_____

Any exposure to (pls circle if applicable); Tuberculosis, Asbestosis, Lead or specify: _____

Serious injuries or accidents: _____

❑ have you had Bronchoscopy when and results: _____,

Echocardiogram when and results: _____,

CAT scan of Chest when and results: _____,

LIST FOR ADDITIONAL USAGE:

_____

_____

_____

_____

_____

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OFFICIAL USE ONLY: Record Checked by:_____ Entered in EMR_____

Sign and Date_____