



Welcome to Pulmonary Physicians of Kansas City, Inc. In order to insure your best care, it is important that you take the time to complete this medical questionnaire thoroughly. Please list your name and today's date in the space provided at the top of each page .

Name _____ Date of Birth ____ / ____ / ____

Who referred you? _____

What is your main complaint today? _____

How long have you had this problem? _____

Respiratory Assessment Questionnaire: (Please circle Y for Yes or N for No.)

History of coughing?

Y / N Do you wake up in the morning coughing?
If yes, how often? _____

Y / N Do you frequently cough in the morning?

Y / N Do you cough throughout the day?

Y / N Do you wake in the night coughing?
If yes, how often? _____

History of Wheezing?

Y / N When you wake in the morning, do you wheeze or feel chest tightness?
If yes, how often? _____

Y / N Do you wake in the night wheezing?
If yes, how often? _____

Y / N Do you use an inhaler or nebulizer to relieve night time or early morning symptoms?
If yes, how often? _____
Name of medication: _____

History of Congestion?

Y / N Do you have mucus in your chest/throat when you cough?
If yes, how often? _____

Exposure to dust or fumes?

Work exposes you to the following dust or fumes:

History of Shortness of breath?

Y / N When you wake in the morning, are you short of breath?
If yes, how often? _____

Y / N Do you wake in the night, short of breath?
If yes, how often? _____

Y / N Do you feel short of breath while resting?

Y / N Do you feel short of breath during strenuous exercise?

Sleeping problems?

Y / N Excessive daytime sleepiness

Y / N Snoring

Y / N Witnessed apnea (someone has reported you stop breathing during sleep)

Y / N A.M. Headaches

Y / N Difficulty Sleeping

(Please continue filling out this form on the back side...)

Name _____ Date of Birth ____/____/____

Past Medical History:

Surgery:

Name of Surgery	Year	Surgeon	Hospital

If you need more room, check this box and add additional notes on page 4.

Hospitalization:

Year	Reason	Hospital

If you need more room, check this box and add additional notes on page 4.

Past Illnesses: *(Please check any illnesses you've had)*

- | | |
|--|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emphysema | _____ |

When was your last TB skin test? _____

Immunizations: *(Please check all that you've had and list the year in which you had it.)*

- | | |
|--|--|
| <input type="checkbox"/> Tetanus <small>(Year)</small> _____ | <input type="checkbox"/> Chicken Pox <small>(Year)</small> _____ |
| <input type="checkbox"/> Hepatitis <small>(Year)</small> _____ | <input type="checkbox"/> Flu <small>(Year)</small> _____ |
| <input type="checkbox"/> Pneumonia <small>(Year)</small> _____ | <input type="checkbox"/> MMR <small>(Year)</small> _____ |

Have you had a blood transfusion? Y / N

If so, when? _____

Medications:

Please list your current medications: *(include any INHALERS and/or over-the-counter such as Vitamins)*

Medication	Strength	Frequency

If you need more room, check this box and add additional notes on page 4, or ask for supplemental medication list.

Allergies to Medications:

Please list any allergies to medications:

Medication	Type of Reaction

If you need more room, check this box and add additional notes on page 4.

Social History:

History of tobacco use:

Do you smoke cigarettes/cigars? Y / N
 If so, how many per day? _____
 How many years have you smoked? _____
 If you used to smoke, how long ago did you quit? _____

Illicit Drug Use:

Do you use illegal drugs? Y / N
 If so, what type and how often? _____

History of Alcohol Use:

Do you consume alcohol? Y / N
 If so, how many drinks per week? _____

Marital Status: (circle one)

Single / Married / Divorced / Widowed

Children:

Number of children: _____
 Any Medical problems? _____

Caffeine Use:

Do you consume caffeine? Y / N
 If so, how many drinks per day? _____

Environmental History:

Have you ever been exposed to any harmful substances?

Name of Harmful Substance	# of years

If you need more room, check this box and add additional notes on page 4.

Occupational Information:

List all occupations and how long you worked at each:

Occupation	# of Years

If you need more room, check this box and add additional notes on page 4.

Family History

Family Member	Living	Deceased	Age/Age at death	Health Condition or Cause of Death
Father				
Mother				
Spouse				
Siblings	Age/Age at death	Current Health Condition or Cause of Death		

If you need more room, check this box and add additional notes on page 4.

Check any diseases that a blood relative may have had:

_____ Heart Disease _____ Thyroid Disease _____ Congenital Disease
 _____ Allergies _____ TB Other: _____
 _____ High Blood Pressure _____ Cancer _____
 _____ Nervous Illness _____ Diabetes _____

Name _____

Date of Birth ____/____/____

System Review: (Please check all that apply.)

ENT:

- _____ Difficulty hearing
- _____ Earache
- _____ Noises in ears
- _____ Nasal stuffiness
- _____ Nosebleeds
- _____ Persistent hoarseness
- _____ Sore or bleeding gums
- _____ Sore tongue
- _____ Frequent head colds

Eyes:

- _____ Wear glasses
- _____ Impaired vision
- _____ Irritation of eyes
- _____ Watering of eyes

Respiratory:

- _____ Shortness of breath
- _____ Wheezing
- _____ Raise phlegm
- _____ Cough up blood
- _____ Daily cough

Cardiac:

- _____ Chest pain
- _____ Irregular heartbeat
- _____ High blood pressure
- _____ Leg swelling

Gastrointestinal:

- _____ Poor appetite
- _____ Trouble swallowing
- _____ Nausea or vomiting
- _____ Indigestion
- _____ Heartburn
- _____ Abdominal pain or distress
- _____ Gas or bloating
- _____ Constipation
- _____ Blood in stools
- _____ Diarrhea or dysentery

Genitourinary:

- _____ Getting up more than once a night to urinate
- _____ Trouble starting stream
- _____ Trouble emptying bladder
- _____ Blood in urine

Gynecological: (Females Only)

- _____ Menopause
- _____ Hormonal replacement
- _____ Birth control pills

Neurological:

- _____ Bad headaches
- _____ Blackout spells
- _____ Convulsions
- _____ Paralysis
- _____ Numbness of hands
- _____ Numbness of feet
- _____ Musculoskeletal
- _____ Frequent back pain
- _____ Rheumatism or arthritis
- _____ Localized weakness
- _____ General weakness

Psychiatric:

- _____ Nervous or upset
- _____ Feeling depressed
- _____ Difficulty with sex life

Endocrine:

- _____ Hormonal problems
- _____ Heart palpitations
- _____ Bulging eyes

Integumentary:

- _____ Sebaceous cysts
- _____ Skin cancer
- _____ Lumps in breasts
- _____ Breast cancer

Immune system:

- _____ Multiple infections
- _____ Immune deficiency
- _____ Seasonal allergies

General:

- _____ Fatigue
- _____ Fever or sweats
- _____ Weight loss? Amount _____
- _____ Weight gain? Amount _____

Additional Notes for the Doctor:
