Florida Medical Clinic, P.A.
Pulmonary, Critical Care, and Sleep Medicine
Marian F. Menezes, M.D. FCCP  Theron A. Ebel, M.D., FACP, FCCP  Nathan M. Do, M.D., FCCP

# Patient Questionnaire

It is important to answer the following questions as accurately as possible.

Patient Name: _____ Age: _____ Date: _____

Date of Birth: _________ Place of Birth: _____ Sex: M/F Marital Status:_____

Primary Physician: _____ Who referred you? _____

Current Occupation: _____ Previous Occupation: _____

Highest Level of Education: _____

**Briefly describe the reason for your visit today and what you hope to accomplish.**

**Summary of your PULMONARY history:**

- Concern of a lung disease because of the following symptoms: _____
  _____
- Previously diagnosed with the following lung disease: _____
  _____

**Current Pulmonary Symptoms:** *Please check each symptom and specify **when it began** and whether the problem is **better, stable, or worse.***

- ☐ Shortness of breath
  - At Rest: _____
  - During Exercise: _____
  - At Night: _____
- ☐ Cough:_____
- ☐ Production of Phlegm (sputum):_____
- ☐ Coughing up blood (hemoptysis):_____
- ☐ Chest Whistling or Wheezing: _____
- ☐ Rattling in Chest: _____
- ☐ Frequent Chest Colds: _____
- ☐ Frequent Pneumonia:_____
- ☐ Fluid in Lungs (Pleural Effusion):_____
- ☐ Congestive Heart Failure : _____
- ☐ Other (please specify): _____

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## Pulmonary, Critical Care, and Sleep Medicine

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| Review of CURRENT Systems | | | | | | | |
|---|---|---|---|---|---|---|---|
| **CONSTITUTIONAL** | | **ENT** | | **CARDIAC** | | **Musculoskeletal** | |
| Weight gain | | Hearing loss | | Chest pain/pressure | | Arthritis | |
| Weight loss | | Ringing in ear | | Murmur | | Muscle pain | |
| Fevers | | Earaches | | Abnormal EKG | | Back pain | |
| Chills | | Sinus Infections | | Heart Flutter | | Neck pain | |
| Sweats | | Nasal Congestion | | Ankle Swelling | | Muscle weakness | |
| Fatigue | | Post-nasal drip | | Calf Pain | | **NEUROLOGICAL** | |
| **SKIN** | | Nosebleeds | | Difficulty lying flat | | Seizures | |
| Rash/Sores | | Nasal polyps | | **GASTROINTESTINAL** | | Paralysis | |
| Lesions | | Deviated septum | | Heartburn | | Numbness | |
| Itching | | Oral ulcers | | Nausea/Vomiting | | Dizziness | |
| **EYES** | | Sore throat | | Pain swallowing | | Tremors | |
| Glasses/contacts | | Hoarseness | | Abdominal pain | | Memory loss | |
| Pain | | **Hematologic/Lymph** | | Diarrhea | | Headaches | |
| Blurry vision | | Easy bruising | | Constipation | | Head trauma | |
| Double vision | | Bleeding gums | | Jaundice | | **PSYCHIATRIC** | |
| Glaucoma | | Excessive bleeding | | Poor appetite | | Anxiety | |
| Cataracts | | Enlarged Glands | | Rectal Bleeding | | Depression | |
| | | | | | | Mood swings | |

| Past Personal History | | | | | | | |
|---|---|---|---|---|---|---|---|
| Alcoholism | | Colitis | | Heart Attack | | Sinusitis | |
| Anemia | | Depression | | Hepatitis | | Sleep Apnea | |
| Anorexia | | Diabetes | | High Cholesterol | | Stomach Ulcers | |
| Anxiety | | Emphysema | | HIV/AIDS | | Stroke | |
| Arthritis | | Epilepsy | | Kidney Stones | | Thyroid (high/low) | |
| Bleeding Disorder | | Glaucoma | | Lung Cancer | | Tuberculosis | |
| Blood clots | | Goiter | | Migraines | | | |
| Bronchitis | | Gout | | Pacemaker | | | |
| Bronchiectasis | | Hay Fever | | Pneumonia | | | |
| Cancer | | High BP | | Polio | | | |
| Cataracts | | Heart Disease | | Rheumatic Fever | | | |

**Past Surgical History**
Please list procedure and date

_____
_____
_____
_____

**Previous Diagnostic Testing**
Please list test (CXR,CT, etc) and date

_____
_____
_____
_____

**Immunizations**
Date last received

Pneumonia _____
Influenza _____
Tetanus _____
Shingles _____

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| Social History | | | | |
|---|---|---|---|---|
| **Use** | **YES** | **NO** | **Current/Past** | **If yes, how much and for how long?** |
| Cigarettes | | | | |
| Cigars | | | | |
| Pipe | | | | |
| Chewing | | | | |
| Alcohol | | | | |
| Illicit Drugs | | | | |

| Family History | | | | |
|---|---|---|---|---|
| | | | IF DECEASED | |
| | AGE | List any past or present medical conditions. | AGE OF DEATH | CAUSE |
| MOTHER | | | | |
| FATHER | | | | |
| BROTHER | | | | |
| | | | | |
| SISTER | | | | |
| | | | | |
| SPOUSE (M/F) | | | | |
| DAUGHTER | | | | |
| | | | | |
| | | | | |
| SON | | | | |
| | | | | |
| | | | | |

| Allergy: | Reaction: Hives, Itching, etc |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| Medications | | | |
|---|---|---|---|
| | MEDICATION | DOSAGE | FREQUENCY |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |

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# Sleep Disorder History

**Nighttime Details:**

Typical bedtime: _____ Typical wake up time:_____ Weekends:_____# of Pillows:_____

Do you wake during the night? _____ How many times? _____ For what reason? _____

| *Please answer Y or N for the following.* | | | |
|---|---|---|---|
| Bed partner present | | Snoring | |
| Shift work | | Apneas (stop breathing during sleep) | |
| Trouble falling asleep | | Restless Sleep | |
| Nocturia (waking to use the bathroom) | | Trouble Concentrating | |
| Night Sweats | | Memory Problems | |
| Sour Brash (heartburn with regurgitation) | | Shortness of Breath during the day | |
| Morning Headaches | | Shortness of Breath at night | |
| Leg Jerks | | Irritable/Short Tempered | |
| Leg Cramps | | Unusual behaviors at night (explain below) | |
| | | | |

Comment:_____
_____

**Daytime Details:**

Do you consume caffeine? _____ If so, what form and how often? _____

| *Please answer Y or N for the following.* | | | |
|---|---|---|---|
| Do you wake refreshed? | | Do you take naps during the day? | |
| Excessive Daytime Sleepiness | | If so, are the naps planned? | |
| Sleep Paralysis (loss of voluntary movement) | | If you nap, do you wake refreshed? | |
| Cataplexy (sudden loss of muscle tone) | | Weight gain over the past year? | |
| Hallucinations (feeling/seeing something not real) | | Weight gain over the past 5 years? | |

Comment:_____
_____

**Epworth Sleepiness Scale:** *How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation.*

**0 = Would *never* doze**
**1 = *Slight* chance of dozing**
**2 = *Moderate* chance of dozing**
**3 = *High* chance of dozing**

| | |
|---|---|
| Sitting and Reading | _____ |
| Watching TV | _____ |
| Sitting, inactive in a public place (ex: meeting) | _____ |
| As a passenger in a car for an hour without a break | _____ |
| Lying down to rest in the afternoon when time permits | _____ |
| Sitting and talking with someone | _____ |
| Sitting quietly after lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |