Florida Medical Clinic, LLC
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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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	_____