Patient Respiratory Medical History

Date: _____

Patient Name_____ □ Male □ Female DOB: _____

What problems are you having with your breathing _____

_____

What makes you short of breath? (example walking, stairs, housework etc.) _____

_____

Do you produce any sputum or phlegm? _____

If yes how often? _____ What color? _____

Do you wheeze? □ Yes □ No If yes what may bring it on? _____

Do you cough? □ Yes □ No If yes what may bring it on? _____

Does □ laughing, □ cold air, □ warm or hot air, □ talking on the phone: worsen your respiratory symptoms? If yes explain_____

Do you have problems with postnasal drainage? □ Yes □ No. Do you have to frequently clear your throat?_____

Do you cough at night or during your sleep? □ Yes □ No

Do you currently cough up any blood? □ Yes □ No If yes how much and how often? _____

_____

Have you ever coughed up blood in the past? _____

Have you been exposed to Tuberculosis (TB)? □ Yes □ No If yes explain_____

Have you ever had a positive TB skin test? □ Yes □ No If yes explain _____

Have you ever been exposed to asbestos? □ Yes □ No If yes explain _____

_____

Do you have problems with reflux or heart burn? □ Yes □ No If yes explain_____

_____

Have you ever had pneumonia? □ Yes □ No If yes explain_____

Have you been hospitalized for pneumonia? □ Yes □ No If yes when? _____

Have you ever had a Pneumovax 23 vaccine for pneumonia? □ Yes □ No If yes when_____

Have you ever had a Prevnar 13 vaccine for pneumonia? □ Yes □ No If yes when_____

Have you had a flu vaccine? □ Yes □ No If yes when was your last vaccine? _____

Have you ever been diagnosed with: □ COPD, □ Emphysema, □ Chronic Bronchitis

□ Asthma as child □ Asthma as an adult

Any emergency room/urgent care visits regarding your Asthma? _____

Have you taken steroids (prednisone) □ currently, □ recently or □ in the past? If yes, please explain?_____

Do you wear oxygen? □ Yes □ No If yes when was it started_____

Do you have any intolerance to aspirin? □ Yes □ No If yes explain_____

Does your intolerance to aspirin affect your breathing? _____

Have you ever had a □ blood clot in your legs (DVT) or in a □blood clot in your lungs (PE)?

If yes explain_____

Any problems with chest pain? _____

What may bring on your chest pain? _____

What improves your chest pain? _____

Does it radiate □ Yes □ No If so where to _____

Intensity on a scale of 1 to 10 (10 being the worse) 0 1 2 3 4 5 6 7 8 9 10

Have you been told that you:

□ Snore? □ Have pauses in your breathing during sleep? □ Tired during the daytime?

Any risk factors for the HIV virus: □ blood transfusion, □ multiple sexual partners, □ IV drug use

Do you have any? □ headaches □ blood in your stools □ fever □ chills □ diarrhea □ nausea □ vomiting □ joint aches □ rashes □ weight loss □ night sweats