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New Patient Questionnaire

Name: _____ **Date**:_____

I was referred by: _____

My doctors include: _____

_____

I have had chest imaging (chest x-rays or CT chest) from:

- ☐ Radiology Imaging Associates (RIA)
- ☐ Cleveland Clinic-Martin Memorial
- ☐ St. Lucie Medical Center (SLMC)
- ☐ Lawnwood Regional Medical Center (LRMC)
- ☐ Diagnostic Radiology Testing Center (DRCTC)
- ☐ iCare Radiology
- ☐ Other: _____

What is the MAIN reason you are seeing Dr. Pamer?

- _____ **Shortness of breath**
- _____ **Cough**
- _____ **Asthma or COPD**
- _____ **Lung nodule/mass**
- _____ **Pulmonary fibrosis**
- _____ **Sleep apnea**
- _____ **Other**

How long have you been short of breath? _____ (days, months, years)

How long have you been coughing? _____ (days, months, years)

Were you born premature? _____ **Did you have asthma as a child?** _____

WHEN do you experience shortness of breath?

- _____ "I am too breathless to leave the house or I am breathless when dressing"
- _____ "I stop for breath after walking about 100 yards or after a few minutes on level ground"
- _____ "On level ground, I walk slower than people of the same age because of breathlessness, or I have to stop for breath when walking at my own pace"
- _____ "I get short of breath when hurrying on level ground or walking up a slight hill"
- _____ "I only get breathless with strenuous exercise"

How often do you get short of breath?

- _____**Every day**
- _____**Occasionally**
- _____**Rarely**
- _____**Never**

How often do you cough?

- _____**Every day**
- _____**Occasionally**
- _____**Rarely**
- _____**Never**

How severe is your shortness of breath or cough?

_____ "Nothing at all" (0 out of 10)
_____ "Very, very slight" (0.5 out of 10)
_____ "Very slight" (1 out of 10)
_____ "Slight" (2 out of 10
_____ "Moderate" (3 out of 10)
_____ "Somewhat severe" (4 out of 10)
_____ "Severe" (5 out of 10)
_____ "Severe" (6 out of 10)
_____ "Very severe" (7 out of 10
_____ "Very severe" (8 out of 10)
_____ "Very, very severe" (9 out of 10)
_____ "Maximal" (10 out of 10

What makes your breathing or cough worse?

_____ Activity/Exertion
_____ Bending over
_____ Exposure to tobacco smoke
_____ Exposure to perfumes,colognes, scents.
_____ Upper respiratory tract infection
_____ Laughing
_____ Allergies
_____ Animals (cats, dogs, etc.)
_____ Cold weather
_____ Hot weather
_____ Emotional stress
_____ Aspirin use
_____ Motrin (ibuprofen), Advil (ibuprofen), Aleve (sodium naproxium), Celebrex (celecoxib), Mobic (meloxicam)

Other: _____

What improves your shortness of breath?

_____ Rest
_____ Medications: Advair, Spiriva, Brovana, Perforomist, Symbicort, Dulera, Albuterol, ipratropium bromide, Xopenex (levalbuerol), etc.
_____ Oxygen
_____ Steroids: Prednisone, Medrol (methylprednisolone), etc.
_____ Xanax (alprazolam), Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam)
_____ Morphine, hydrocodone, oxycodone, Dilaudid (hydromorphone)
_____ Other medication(s): _____

Other: _____

You also have associated symptoms of:

_____ Nonproductive (dry) cough
_____ Productive cough with _____colored sputum
_____ Wheezing
_____ Chest tightness
_____ Chest pain
_____ Nasal congestion
_____ Runny nose
_____ Nasal itching
_____ Post−nasal drip
_____ Sneezing
_____ Watery eyes
_____ Acid−bitter taste in throat
_____ Heartburn
_____ Waking up short of breath
_____ Short of breath laying flat
_____ Ankle swelling
_____ Hoarseness
_____ Nose bleeds
_____ Hives
_____ Sore throat
_____ Throat closing
_____ Throat tightness
_____ Hemoptysis
_____ Palpitations
_____ Snoring
_____ Apneic episodes while sleeping
_____ Restless legs
_____ Dizziness
_____ Passing out (syncope)
_____ Muscle weakness
_____ Fevers
_____ Night sweats
_____ Chills
_____ Eczema (dry scaly patches on skin)
_____ Weight gain
_____ Unplanned weight loss
_____ Black tarry stool (melena)
_____ Decrease in appetite

PAST MEDICAL HISTORY

PULMONARY PROBLEMS AND DISEASES

☐ Asthma	☐ Allergies (seasonal type)	☐ COPD (chronic bronchitis or emphysema)
☐ Tuberculosis	☐ Interstitial Lung Disease	☐ Pulmonary Fibrosis
☐ Lupus	☐ Sarcoidosis	☐ Scleroderma
☐ Bronchiectasis	☐ Pulmonary embolism	☐ Pulmonary Hypertension
☐ Obstructive sleep apnea	☐ Cystic Fibrosis	☐ Pneumothorax

☐ Deep venous thrombosis (DVT): *When and where?* _____

☐ Pneumonia - *Approx dates:* _____

CARDIOVASCULAR HISTORY

☐ Coronary artery disease	☐ Heart attack (myocardial infarction)	☐ Atrial fibrillation
☐ Congestive heart failure	☐ I've had a cardiac stent placed	☐ I've had Coronary Artery Bypass Grafting (CABG)
☐ Carotid artery stenosis	☐ Congestive heart failure (CHF) *Ejection fraction (%):* _____	

GENERAL MEDICAL HISTORY

☐ Anemia	☐ Anxiety	☐ Chronic kidney disease (CKD)	☐ Stroke
☐ Allergic rhinitis	☐ High Cholesterol	☐ High Blood Pressure	☐ Chronic sinusitis
☐ Eczema	☐ Depression	☐ Diabetes mellitus	☐ Diabetic neuropathy
☐ Diabetic nephropathy	☐ GERD	☐ Fibromyalgia	☐ Hypothyroidism
☐ Glaucoma	☐ Rheumatoid arthritis	☐ Allergies (seasonal type)	☐ Restless legs syndrome

What other medical conditions do you have? _____

_____

_____

_____

_____

_____

PAST SURGICAL HISTORY

☐ Appendectomy	☐ Tubal Ligation	☐ C-Section	☐ Cholecystectomy
☐ Hip Surgery	☐ Hysterectomy	☐ Knee Surgery	☐ Shoulder Surgery

Any additional surgeries not listed _____

FAMILY HISTORY

☐ I am adopted and do not know my medical history ☐ I do not know

☐ Allergies	☐ Alpha-one antitrypsin	☐ Asthma	☐ Breast cancer
☐ COPD	☐ Colon cancer	☐ Cystic fibrosis	☐ Diabetes mellitus
☐ High blood pressure	☐ Pulmonary fibrosis	☐ Emphysema	☐ Pulmonary hypertension

Other family conditions: _____

SOCIAL HISTORY

Smoking history:

□ I have never smoked □ I was exposed to ***second-hand smoke*** for _____ years

I *started* smoking at _____ years old
I smoked _____ packs/day
I smoked _____ cigarettes/day
I smoked _____ cigars/day

I *stopped* smoking at _____ years old
I smoked _____ pipes/day
I smoked _____ (describe)
I still smoke_____ (describe)

□ I use cigarettes or vape tobacco. □ I use(d) flavored vape

How often do you drink alcohol? _____

Recreational drug history: _____

What kind of pets do you have? _____

What have you done for occupations? _____

Have you been exposed to anything during your employments that could have damaged your lungs? _____

_____

Occupational Exposures:

□ Asbestos □ Auto body work □ Metal worker □ Welder □ Carpenter □ Wood Dusts
□ Hairdresser □ Nail salon work □ Dental hygienist □ Instrument sterilization
□ Veterinary field □ Farm worker □ Animal exposure □ Fish/seafood worker □ Bait worker
□ Baker □ Flour or cereal exposure □ Latex rubber exposure
□ Other: _____

Recent travel outside of Florida: _____

DRUG ALLERGIES

Name of medication	Reaction

MEDICATIONS

BREATHING MEDICATIONS **(Inhalers, nebulized meds, etc.)**

Breathing Medications	Dosage	Times per day	How long?

REGULAR MEDICATIONS **(ALL OF THEM, *Not just the ones you think are relevant*)**

Regular Medications	Dosage	Times per day	How long?

REVIEW OF OTHER MEDICAL PROBLEMS

In the prior 6 (SIX) months, have you had:

Constitutional Symptoms: □ Chills □ Fatigue □ Fever □ Headache

Allergy/Immunology: □ Blistering of skin. □ Hives. □ Itching. □ Rash.

Ophthalmologic: □ Blurred vision. □ Discharge. □ Eye Pain. □ Itching and redness. □ Red eye.

ENT: □ Decreased hearing. □ Difficulty swallowing. □ Ear pain. □ Ear problems. □ Masses.
□ Nosebleed. □ Sinus pain. □ Sore throat. □ Swollen glands.

Endocrine: □ Acne. □ Cold intolerance. □ Dizziness. □ Excessive sweating. □ Hot flashes.

Respiratory: □ Coughing up blood. □ Pneumonia. □ Shortness of breath at rest. □ Tuberculosis. □ Wheezing.

Cardiovascular: □ Chest pain. □ Chest pain at rest. □ Pain in legs walking (claudication). □ Dizziness.

Gastrointestinal: □ Abdominal pain. □ Constipation. □ Diarrhea. □ Nausea. □ Vomiting.

Genitourinary: □ Nocturnal urination. □ Abdominal pain/swelling. □ Difficulty urinating.
□ Frequent urination. □ Pain in lower back.

Musculoskeletal: □ Back pain. □ Painful joints. □ Sciatica. □ Swollen joints.

Peripheral Vascular: □ Blanching of skin. □ Cold extremities. □ Decreased sensation in extremities.
□ Painful extremities.

Skin: □ Acne. □ Blistering of skin. □ Dry skin. □ Hives. □ Itching. □ Nail changes. □ Rash.

Neurologic: □ Imbalance. □ Difficulty speaking. □ Fainting. □ Headache. □ Paralysis.
□ Tingling/Numbness. □ Transient loss of vision.

Psychiatric: □ Auditory/visual hallucinations. □ Delusions. □ Depressed mood.

SLEEP APNEA EVALUTION

Do you have sleep apnea?

□ I don't know. □ I have been told I have sleep apnea but I have never had a sleep study

□ I have sleep apnea and I use my CPAP _____ nights/week, for _____ hours/night

□ My CPAP settings are: _____ cm H2O

□ I have sleep apnea but I **DO NOT** use my CPAP. *Why not?* _____

How likely are you to doze off or fall asleep in the following eight (8) situations?

0 = No chance of dozing off
1 = Slight chance of dozing off
2 = Moderate chance of dozing off
3 = High chance of dozing off

Situation	**Chance of Dozing Off or Falling Asleep**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (such as a theatre or meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon (when circumstances permit)	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch (without alcohol)	_____
8. In a car, while stopped for a few minutes in traffic	_____
Total Score:	_____

Do you snore? _____ Do you stop breathing when you sleep? _____

Do you feel refreshed when you wake up? _____

What time do you go to bed? _____

How long does it take you to fall asleep? _____

How many times do you wake up at night? _____ Why do you wake up? _____

What time do you wake up in the morning? _____

Do you develop leg pains in the evening/night that make you have to get up to walk them off? _____

Do you wake up with leg cramps? _____

Do you excessively move your legs at night or during sleep? _____

When you wake up, are the bed sheets in place or in excessive disarray? _____

During increased emotion (laughter, sadness, crying), do you lose strength in any part of your body? _____

When you wake up, do you feel paralyzed and unable to move? _____

Are your dreams so vivid and real that it is as if you are living them out in real life? _____

I take medication to help me sleep (NAME): _____