Staple

United Lung & Sleep Clinic
Pulmonary Hypertension Questionnaire

Allina Health
UNITED HOSPITAL

Today's Date _____

Name _____

Date of Birth _____

Who is your primary care provider? _____

Who referred you to our clinic? _____

Have you been evaluated by heart or lung doctors in the past?

Who? _____ When? _____

Who? _____ When? _____

	Yes	No
Have you been told that you have pulmonary hypertension?	☐	☐
Who told you about this problem?_____		
Do you have shortness of breath?	☐	☐
How many years have you had shortness of breath? _____		
Does shortness of breath prevent you from working?	☐	☐
Does shortness of breath prevent you from taking care of yourself?	☐	☐
Does shortness of breath prevent you from doing what you want to do?	☐	☐
Does shortness of breath prevent you from even dressing yourself or fixing meals?	☐	☐
Do you have shortness of breath will sitting still and resting?	☐	☐
Do you have shortness of breath when you lie down at night?	☐	☐

How many pillows do you sleep on at night? _____

	Yes	No
Do you wake up in the middle of the night because you have shortness of breath?	☐	☐
How far can you walk on level ground without stopping?		
(50 ft / 1 block / 1 mile) _____		
Can you climb stairs?	☐	☐
How many floors of stairs? _____		
Do things other than exercise make your breathing worse?		
Odors / smells	☐	☐
Fumes or smoke	☐	☐
Cold or humid weather	☐	☐
Emotions	☐	☐
Other _____	☐	☐
Have you ever been told you have lung disease?		
Asthma	☐	☐
Emphysema	☐	☐
CPOD (chronic obstructive pulmonary disease)	☐	☐
Fibrosis of the lungs	☐	☐
Sarcoidosis	☐	☐
Do you use oxygen at home?	☐	☐
Do you smoke now?	☐	☐
Have you ever smoked? _____	☐	☐
How long and how much? _____		
Do you have chest pain or discomfort?	☐	☐
Chest tightness, heaviness, pressure? _____	☐	☐
Where on your chest is the pain? _____		
How long does it last? _____		
Does it happen at rest?	☐	☐
Does it happen during exercise?	☐	☐
Have you ever fainted or collapsed	☐	☐
Do you ever feel your heart beating fast or irregularly?	☐	☐
Has anyone told you that you have heart disease?	☐	☐
What were you told? _____		
Have you ever had a heart attack?	☐	☐
Have you ever had heart surgery?	☐	☐
If yes, at what age? _____		
Have you been told that you have a heart murmur?	☐	☐

	Yes	No
Have you been told that you have a large heart?	☐	☐
Is there any family history of heart disease?	☐	☐
Connective Tissue Disease or Collagen Vascular Disease		
Have you been diagnosed with any of the following diseases?		
Lupus	☐	☐
Scleroderma	☐	☐
Rheumatoid arthritis	☐	☐
Mixed connective tissue disease	☐	☐
Other types of arthritis? _____	☐	☐
Have you been told you have Raynaud's disease?	☐	☐
Do your fingers or hands turn blue in the cold?	☐	☐
Have you ever been told that you have HIV (human immunodeficiency virus) or AIDS (acquired immune deficiency syndrome)?	☐	☐
Have you ever been concerned that you have HIV or AIDS?	☐	☐
Have you ever had a blood transfusion?	☐	☐
When? _____		
Have you ever been told you have anemia?	☐	☐
Do you know what type of anemia? _____		
Is there a history of anemia in the family?	☐	☐
Have you ever had a bone marrow test?	☐	☐
Have you ever been told that you have had clots in the veins of your legs? This is also called deep vein thrombosis (DVT).	☐	☐
Have you ever been told that you have clots in your lungs? This is also called pulmonary embolism (PE).	☐	☐
Has anyone in your family had DVT or PE?	☐	☐
Have you used diet pills?	☐	☐
When? _____		
Which pills? _____		
Have you ever been exposed to methamphetamine (meth)?	☐	☐
Have you ever been told that you have sleep apnea?	☐	☐
If yes, are you still treating it? _____	☐	☐
Are you being treated for sleep apnea?	☐	☐
Do you snore at night?	☐	☐
Do you have trouble staying awake during the day?	☐	☐

	Yes	No
Have you ever had trouble with your liver?	☐	☐
Do you have cirrhosis or a scarred liver?	☐	☐
Have you had jaundice?	☐	☐
Do you drink alcohol?	☐	☐

How often? _____

How much? _____

Have you ever been treated for a cancer with chemotherapy?	☐	☐

What type of cancer? _____

Have you ever been told you have thyroid disease?	☐	☐

Treatment?_____

For Women:

Do you use any contraceptive (birth control) medicine?	☐	☐
Do you use any other method of birth control?	☐	☐
Are you or do you think you might be pregnant?	☐	☐

Current Medicines:

Please bring a list of all medicines you are currently taking, including prescription or over the counter medicines or any dietary, herbal, natural or vitamin supplements to your appointment.

Medicine Allergies:

_____

_____

Past Medical History

Previous Surgery:

_____

_____

_____

_____

_____

_____

Have you ever had a splenectomy? (Surgery to remove your spleen)	☐	☐

Previous hospital stays not related to surgery:

_____

_____

_____

Other medical problems not mentioned above:

_____

_____

Social History

Single _____ Married _____ Divorced _____ Spouse has died _____

Number of children _____

Ages _____

Working _____ Retired _____ Disabled _____

Occupation(s) / Profession(s)

_____

_____

_____

Family History

Mother: Living _____ Age _____ Died _____ Age _____

Health problem(s)_____

Cause of death _____

Father: Living _____ Age _____ Died _____ Age _____

Health problem(s) _____

Cause of death _____

Sisters: Number Living _____ Number died _____

Health problem(s) _____

Cause(s) of death _____

Brothers: Number Living _____ Number Died _____

Health problem(s) _____

Cause(s) of death _____

Other family health problems:

Osler-Weber-Rendu syndrome (Hereditary Hemorrhagic Telangiectasia) Y / N

_____

_____

Review of Systems

	Yes	No
Weight gain / How much? _____		
Weight loss / How much? _____		
Fever or chills	☐	☐
Sweats during the night	☐	☐
Fatigue (tiredness)	☐	☐
Swelling in legs	☐	☐
Bleeding more than you think is normal	☐	☐
Headaches	☐	☐
morning _____		
other times_____		
Weakness in one arm or one lag	☐	☐
Stroke	☐	☐
Numbness in one arm or one leg	☐	☐
Falling down or unsteady	☐	☐
Diabetes	☐	☐
High blood pressure / How long? _____	☐	☐
Kidney infection	☐	☐
Kidney failure	☐	☐
Kidney dialysis	☐	☐
Kidney stones	☐	☐
Hayfever	☐	☐
Sinusitis	☐	☐
Problems swallowing	☐	☐
Heartburn or indigestion	☐	☐
Esophageal reflux (GERD)	☐	☐
Stomach or duodenal ulcers	☐	☐
Ulcerative colitis or Crohn's disease	☐	☐
Bleeding from the stomach or intestines	☐	☐
Dry eyes	☐	☐
Other visual problems _____		