Date _____

Name_____ _____ _____ Date of birth_____
Last First MI

**What lung problem do you want us to help you with:**

_____

Who is your primary care provider?_____

**Social History**

Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Number of children_____

Are you currently: Working [ ] Retired [ ]
Unemployed [ ] Disabled [ ]

Occupation(s)
List most recent first (including former careers if you are retired or not working):

1) _____

2) _____

Leisure activities: _____

_____

**Please answer these questions with regard to your current health status.**

**Trouble Breathing** (hard to breathe, chest tightness, shortness of breath)

How long have you been bothered by shortness of breath? _____

**Shortness of Breath Scale**

Medical Research Council (MRC) Dyspnea. Mark all that apply to you:

[ ] Not troubled with breathlessness except with strenuous exercise
[ ] Troubled by shortness of breath when hurrying on the level or walking up a slight hill
[ ] Walks slower than people of the same age on the level **because of breathlessness** or has to stop for breath when walking at own pace on the level
[ ] Stops for breath after walking about 100 yards or after a few minutes on the level
[ ] Too breathless to leave the house or breathless when dressing or undressing

| | **Yes** | **No** |
|---|---|---|
| Do you have shortness of breath when you lie down in bed? | [ ] | [ ] |
| How often?_____ | | |
| Do you wake up in the middle of the night with shortness of breath? | [ ] | [ ] |
| Do you wheeze or make noise when you breathe? | [ ] | [ ] |

What situations, places or activities make your shortness of breath worse?

| | | | |
|---|---|---|---|
| Dust or fumes | [ ] | Weather changes/humidity | [ ] |
| Tobacco smoke | [ ] | Perfumes | [ ] |
| Wood smoke | [ ] | Emotions | [ ] |
| Exercise | [ ] | Household cleaning solutions | [ ] |
| Cold air | [ ] | | |

Things that will make your breathing better:_____

| **Cough** | **Yes** | **No** |
|---|---|---|
| Do you cough often? | [ ] | [ ] |
| If not every day, how often?_____ | | |
| How many years have you been coughing?_____ | | |
| Do you cough up phlegm (sputum) when you do cough? | [ ] | [ ] |
| Have you had blood in your phlegm | [ ] | [ ] |

| **Chest Pain** | **Yes** | **No** |
|---|---|---|
| Do you have chest pain? | | |
| Only during activity? | [ ] | [ ] |
| Only when breathe? | [ ] | [ ] |

| **Tobacco Use (Cigarettes)** | **Yes** | **No** |
|---|---|---|
| Have you ever smoked cigarettes regularly? | [ ] | [ ] |
| Do you **still** smoke? | | |
| Do you have a plan to quit? | [ ] | [ ] |
| Do you want help to quit? | [ ] | [ ] |

How old were you when you first started regularly smoking cigarettes? _____

If you stopped smoking completely, how old were you when you stopped? _____

How many cigarettes per day do (did) you smoke on an average?_____

How many years altogether have you smoked?_____

| | **Yes** | **No** |
|---|---|---|
| Do you smoke e-cig | [ ] | [ ] |
| Do you smoke marijuana or use recreational drugs | [ ] | [ ] |
| Do you smoke cigars? | [ ] | [ ] |
| Do you smoke a pipe? | [ ] | [ ] |
| Do you chew tobacco? | [ ] | [ ] |

| **Past Tests** | **Yes** | **No** |
|---|---|---|
| Have you had a chest X-ray? | [ ] | [ ] |
| Have you had pulmonary function tests (breathing tests)? | [ ] | [ ] |
| Have you ever had a skin test for tuberculosis (TB) (PPD, Mantoux or Tuberculin test?) | [ ] | [ ] |
| Positive____ Negative____ Unknown____ | | |

**Allergies**

| | Yes | No |
|---|---|---|
| Have you ever been told by a health care provider that you have allergies? | [ ] | [ ] |
| Have you ever had allergy **tests**? | [ ] | [ ] |
| When? _____ | | |
| Where?_____ | | |
| Have you ever had allergy **shots**? | [ ] | [ ] |
| When? _____ | | |
| Have you ever been told you have **hay fever**? | [ ] | [ ] |

Environmental Allergies

| Substance (such as pollen, mold, eggs, food, animals, etc.) | Symptoms (such as rash, trouble breathing, wheezing, etc.) |
|---|---|
| | |
| | |
| | |
| | |
| | |

**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.

| | Yes | No |
|---|---|---|
| Do you use inhalers regularly/as prescribed | [ ] | [ ] |
| Do you use oxygen | [ ] | [ ] |
| Do you use CPAP | [ ] | [ ] |

**Medical History to be completed if you do have a Allina Primary provider**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Asthma | [ ] | [ ] | Treated for sinusitis (sinus infection) | [ ] | [ ] |
| Emphysema | [ ] | [ ] | Postnasal drainage | [ ] | [ ] |
| Pneumonia | [ ] | [ ] | Nasal polyps | [ ] | [ ] |
| Tuberculosis | [ ] | [ ] | Allergy to aspirin | [ ] | [ ] |
| Other lung diseases | [ ] | [ ] | | | |

Surgeries (type and approximate date)

_____

_____

**Family History**

Has anyone in your family (grandparents, aunts, uncles, brothers, sisters, parents, children) had any of these medical problems?:

Asthma: _____

Emphysema: _____

Lung cancer: _____

Blood clots in the lungs: _____

Other lung diseases: _____

Heart problems: _____

**Home Environment**

What type of building do you live in? Apartment____ House____ Mobile home____ Other _____

How long have you lived in your home?_____

Age of your home _____years

Are you aware of any water problems in your home? _____

Heat: forced air_____ hot water baseboard_____ other_____ (please specify)

Air conditioning: central_____ room_____ none_____

Pets: cats_____ dogs_____ birds_____ other_____

Neighborhood air pollution_____ (chemical plant, factory, etc.)

**Review of Systems**

Check any current or chronic (long-lasting) problems.

**General:**
- ☐ Fatigue (tiredness)
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Other_____

**Eyes:**
- ☐ Drainage/discharge
- ☐ Vision loss
- ☐ Other_____

**Ears, nose, mouth, throat:**
- ☐ Ear drainage
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Ringing in ears
- ☐ Facial pain
- ☐ Hoarseness
- ☐ Other_____

**Cardiovascular:**
- ☐ Chest pain
- ☐ Pain in legs when walking
- ☐ Irregular heartbeat
- ☐ Swelling in legs
- ☐ Other_____

**Gastrointestinal:**
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Blood in stools
- ☐ Other_____

**Musculoskeletal:**
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Other _____

**Genitourinary:**
- ☐ Burning with urination
- ☐ Frequency of urination
- ☐ Blood in urine
- ☐ Abnormal vaginal bleeding
- ☐ Other_____

**Hematology:**
- ☐ Easy bleeding
- ☐ Easy bruising

**Neurologic:**
- ☐ Trouble with walking or balance
- ☐ Seizures
- ☐ Numbness and tingling
- ☐ Trouble with speech
- ☐ Headaches
- ☐ Decreased alertness
- ☐ Other_____

**Psychiatric:**
- ☐ Anxiety
- ☐ Depression
- ☐ Other_____

**Endocrine:**
- ☐ Hotter or colder than others
- ☐ Excessive thirst
- ☐ Excessive appetite
- ☐ Other_____

**Allergic/Immunologic:**
- ☐ Food allergies_____
- ☐ Medicine allergies_____
- ☐ Seasonal allergies
- ☐ Frequent infections
- ☐ Other_____

**Skin:**
- ☐ Itching
- ☐ Rashes
- ☐ Other_____