GRANGER
SLEEP & LUNG

Pulmonary History Questionnaire

Date: _____

Patient Name	Patient ID:	Age:	Birth Date:	Height:	Weight:

Primary Care Physician:		

Briefly describe reason for today's visit:

Medical Problems / Hospitalizations / Surgeries	Current Medications / Doses
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

Other Medical History (check box)

☐ ChickenPox	☐ Measles
☐ Mumps	☐ Malaria
☐ Pneumonia	☐ Scarlet Fever
☐ Rheumatic Fever	☐ Whooping Cough
☐ Tuberculosis	☐ Last TB Skin Test Date: _____/_____/_____

Medication Allergies / Reactions:

Annual Influenza Vaccines?	☐ Yes	☐ No
Pneumovax?	☐ Yes	☐ No

Your Social History:

Marital Status:	☐ Single	☐ Married	☐ Widowed	☐ Divorced
Children:	☐ Yes	☐ No	Number:_____	
Do you keep animals at home?	☐ Yes	☐ No		
☐ Cats	☐ Birds	☐ Dogs		

Tobacco: ☐ Cigarettes ☐ Cigars ☐ Pipe

_____Packs / day | Age started smoking?_____

Age when quit? _____ | Still smoking? ☐ Yes ☐ No

Substance Use: _____beers / week | _____ glasses wine / week | _____ozs. Hard liquor / week

☐ Cocaine ☐ Amphetamines ☐ IV Drugs

Your Family History:

Please check illnesses that have occurred in your blood relatives? (check box, describe and indicate relatives).

	Relative (s)		Relative(s)
☐ Cholesterol		☐ Allergies (Type) _____	
☐ Strokes		☐ Asthma	
☐ Emphysema		☐ Sleep abnormalities (any kind)_____	
☐ Cystic Fibrosis		☐ Narcolepsy	
☐ Early Emphysema		☐ Problems staying awake	
☐ Tuberculosis		☐ Sleep Apnea	
☐ Cancer (Type) _____		☐ Diabetes	
☐ Heart Disease		☐ Hypertension	
☐ Heart Attacks		☐ Other significant conditions:	
☐ Heart Rhythm Problems			
☐ Kidney Diseases			
☐ Hepatitis			

Employment History:

Are you working now? ☐ Yes ☐ No

What is (or was) your occupation?

Have you been exposed to asbestos or dust or strong fumes at work? ☐ Yes ☐ No

If "Yes" above, please describe:

Do you have: ☐ Living will ☐ Organ Donor Card ☐ Durable Power of Attorney

Travel History / Birthplace:

	U.S. (States)	Foreign (Countries)
Last Year?		
Last 10 Years?		

Patient Signature:_____

Date_____

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Have you ever had: (check)

General
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue/ Weakness
- ☐ Fever
- ☐ Excessive Sleepiness
- ☐ Heavy Snoring
- ☐ Rash

Head
- ☐ Headache
- ☐ Head Injury

Eyes
- ☐ Vision Changes
- ☐ Last Eye Exam ___/___/___
- ☐ Glaucoma
- ☐ Cataracts

Hearing
- ☐ Hearing Loss
- ☐ Ringing
- ☐ Dizziness
- ☐ Earaches
- ☐ Infection

Nose/Sinuses
- ☐ Frequent Colds
- ☐ Nasal Stuffiness
- ☐ Discharge
- ☐ Hayfever
- ☐ Nosebleeds
- ☐ Sinus Trouble

Neck
- ☐ Lumps

Mouth
- ☐ Sore Throat
- ☐ Bleeding Gums
- ☐ Hoarseness

Breasts
- ☐ Lumps or Nipple Discharge

Lung Problems
- ☐ Cough
- ☐ Sputum
- ☐ Bloody Sputum
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Short of Breath
- ☐ Last Chest X-ray ___/___/___ (date)

Heart Problems
- ☐ High Blood Pressure
- ☐ Chest Pain or Discomfort
- ☐ Breathlessness with Exertion
- ☐ Breathlessness while Lying Flat
- ☐ Swelling of Lower Extremities
- ☐ Heart Attack ___/___/___ (date)
- ☐ Heart Surgery ___/___/___ (date)

Cancer
- ☐ Type _____ When _____

Endocrine
- ☐ Thyroid Trouble
- ☐ Diabetes
- ☐ Excessive Thirst or Hunger

Patient Signature: _____

Have you ever had: (check)

Stomach/Intestinal
- ☐ Difficulty Swallowing
- ☐ Painful Swallowing
- ☐ Heartburn
- ☐ Decreased Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bleeding from the Rectum
- ☐ Hemorrhoids
- ☐ Tarry Black Stools
- ☐ Abdominal Pain
- ☐ Liver or Gallbladder Trouble
- ☐ Hepatitis

Kidneys/Bladder
- ☐ Increased Urine Frequency
- ☐ Increased Urination at Night (times/ night)
- ☐ Burning or Pain with Urination
- ☐ Bloody Urine
- ☐ Difficulty in Starting Urine Stream
- ☐ Urinary Tract Infections
- ☐ Kidney Stones

Male
- ☐ Hernia
- ☐ Testicular Pain
- ☐ Venereal (Sexually Transmitted) Disease
- ☐ Impotence

Female
- ☐ Abnormal Vaginal Bleeding
- ☐ Venereal (Sexually Transmitted) Disease
- ☐ Last Pelvic Exam / Pap Smear _____
- ☐ Last Breast Exam _____
- ☐ Last Mammogram_____

Muscle/Skeletal
- ☐ Muscle or Joint Pains
- ☐ Arthritis
- ☐ Gout
- ☐ Joint Swelling

Skin
- ☐ Rash, Dryness, Itching
- ☐ Psoriasis
- ☐ Exema

Psychiatric
- ☐ History of Psychiatric Hospitalization
- ☐ Depression
- ☐ Anxiety

Blood/Lymph System
- ☐ Anemia
- ☐ Easy Bruising or Bleeding
- ☐ Blood Clots in the Legs or Lungs
- ☐ Transfusions or Transfusion Reactions
- ☐ Swollen Lymph Nodes
- ☐ Lymphoma
- ☐ Leukemia

Neurologic
- ☐ Fainting
- ☐ Seizure
- ☐ Paralysis
- ☐ Stroke
- ☐ Numbness
- ☐ Tingling
- ☐ Brain Tumor

Immunologic
- ☐ Other Allergies _____
- ☐ Lupus
- ☐ Vasculitis