CAROLINA LUNG
& CRITICAL CARE
ROPER ST. FRANCIS PHYSICIANS

New Patient Questionnaire

NAME: ________________________________ AGE: _______ DATE: ______________
Address: ____
Primary Care Physician: ____________________ Referred By: ____________________
REASON FOR YOUR VISIT TODAY? ____

____

Past Medical Problems

	YES	NO
Heart Problem		
Stroke		
Emphysema		
Asthma		
GERD		
Thyroid Disease		
Liver Problems		
Arthritis		
Glaucoma		
Brittle Bones		
Cancer		
High Blood Pressure		

	YES	NO
Diabetes		
Cholesterol		
Sleep Apnea		
Chronic Bronchitis		
Blood Clots		
Recurrent lung infection		
Sinusitis		
Sarcoidosis		
Heart Failure		
Heart Attack		
Arrhythmia		

MAJOR SURGERIES AND HOSPITALIZATIONS

DATE	PROCEDURE

MEDICATION ALLERGIES

MEDICATION	REACTION

MEDICATION YOU ARE TAKING

(or attach a complete list including prescription and non-prescription meds)

NAME	STRENGTH	FREQUENCY		NAME	STRENGTH	FREQUENCY

SOCIAL HISTORY

Have you ever smoked?	**YES**	**NO**
At what age did you begin?		
At what age did you quit?		
How many packs a day?		
How Did you quit?		
How often do you drink alcohol?		
Do you have children	**YES**	**NO**
What kind of work do/did you do?		

Have you ever been exposed to mold?	**YES**	**NO**	
Have you ever been tested for mold exposure	**YES**	**NO**	**When:**
Any Pets?		**What kind?**	

Where were you born?	
Where have you lived?	
Traveled in the last 5 years?	

Exposure Concerns?

	Yes	NO
• **Stone Cutting**		
• **Sand Blasting**		
• **Welding**		
• **Plumbing**		
• **Coal Mining**		
• **Ship Yard**		
• **Fire Fighting**		
• **Chemicals**		
• **Asbestos**		
• **Other**		

FAMILY HISTORY

(Please note if deceased and age at death)

	Mother	Father	Siblings	Children
Asthma				
Emphysema				
Heart Attacks				
High Blood Pressure				
Stroke				
Diabetes				
Sleep Apnea				
Cancer-				
-Type Cancer				

SLEEP QUESTIONS

Have you had a sleep study? Y N If Yes Where and When?		
What time do you Typically go to bed?		
What time do you Typically get out of bed?		
Do You Snore?		
Have you been told you stop breathing during sleep?		
Do you use sleeping pills	Yes	NO
Do you have Restless Legs	Yes	NO

On average, how much of these beverages do you drink?

		During a typical Day	Within 2 hours of bedtime
Coffee (caffeinated)	Cups		
Tea (caffeinated)	Cups		
Soda (caffeinated)	Cans		

Are you currently using CPAP: _____ If Yes, What Pressure? ______________________

And from what vender is your CPAP from? ____________________________________

REVIEW OF SYSTEMS

Have you had any of the following in the last 6 months?
(check yes or no and if yes circle symptom if positive)

	Yes	No	Symptom
Constitutional			Fever, Chills, Night Sweats, Weight Loss, loss of appetite
Eye			Vision Change, Cataracts, Double Vision
ENT			Hoarseness, nasal drip, Seasonal Allergies, Throat Clearing
Respiratory			Cough Sputum, Shortness of breath, coughing blood, Wheezing
Cardiac			Chest pain, Shortness of breath, Palpitations, Leg Swelling
GI			Nausea, vomiting, diarrhea, Difficulty Swallowing
GU			Bloody Urine
Endo			Frequent urination, Frequent thirst
Skin			Rash
Heme/Lymph			Abnormal bleeding, leukemia / lymphoma, history of blood clots
Neurology			Vertigo, new headaches, seizures
Muscular/Skeletal			Arthritis – What Type? _________ Gout
Infectious			Ever had a TB test? positive or negative

XRAY

- **When was your last Chest x-ray?** ____________________________________
  - **Where was it taken?** ____
- **Have you had a C/T Scan?** ____
  - **Where was it performed?** ____________________________________

IMMUNIZATIONS

Pneumovax ®	Yes	No
If Yes When		
Flu	Yes	No
If Yes When		
Shingles Injection	Yes	No
If Yes When		
Last TB Test		