PITTSBURGH PULMONARY ASSOCIATES
NEW PATIENT QUESTIONNAIRE

Name: _____ ***Date:*** _____ ***DOB:*** _____ ***Age:*** _____

Height: _____ ***Weight:*** _____ ***Referred by:*** _____ ***PCP*** _____

Medication Allergies:	***Reaction:***

Date of last flu vaccine: _____ Last Pneumovax: _____

Positive skin test for tuberculosis: Yes ☐ No ☐

Chief complaint (why are you here today and how long you have had these symptoms?) _____

_____

_____

Past Medical History

Have you had any of the following disorders?

Yes	No		Yes	No	
		Allergies (environmental)			Pulmonary Fibrosis
		Asthma			Pneumonia
		Blood Clots - Lung/Leg			Sarcoidosis
		COPD / Emphysema			Sinus Disease
		Lung Cancer			Sleep Apnea
		Pleurisy			Tuberculosis
		Anemia			High Cholesterol / Lipids
		Anxiety			Irregular Heartbeat
		Arthritis			Kidney Disease
		Cancer (where?) _____			Liver Disease
		Congestive Heart Failure			Obesity
		Coronary Artery Disease			Poor Circulation
		Depression			Seizures
		Diabetes / sugar			Stroke
		Heart Attack			Thyroid Disease
		High Blood Pressure			Ulcers / Reflux

Hospitalizations

Date		Diagnosis		Date		Diagnosis	
Date		Diagnosis		Date		Diagnosis	
Date		Diagnosis		Date		Diagnosis	
Date		Diagnosis		Date		Diagnosis	
Date		Diagnosis		Date		Diagnosis	

Past surgical history

Date		Procedure		Date		Procedure	
Date		Procedure		Date		Procedure	
Date		Procedure		Date		Procedure	
Date		Procedure		Date		Procedure	
Date		Procedure		Date		Procedure	

Medications - please include inhalers

Name	Dose	Frequency	Name	Dose	Frequency

Do you have: Yes No

Cough ☐ ☐ If so, for how long? _____

What brings on your cough? _____

Sputum ☐ ☐ If so, what color? _____

Bloody Sputum ☐ ☐

Shortness of breath ☐ ☐ If so, for how long? _____

At rest ☐ ☐

With Activity ☐ ☐ What activity causes it? _____

At Night ☐ ☐

Snore ☐ ☐ Daytime sleepiness? Yes ☐ No ☐

Ankle Swelling ☐ ☐

Do you wear oxygen ☐ ☐ How many liters? ☐

Wear it at rest? ☐ With activity? ☐ With sleep? ☐

Did you ever have a sleep study? (as an out patient?) Yes ☐ No ☐ Where? _____

Do you wear a C-PAP or Bi-PAP? Yes ☐ No ☐ Which one? _____

Settings _____ What company provides it? _____

Social History / Family History

Did you ever smoke? Yes ☐ No ☐

Do you still smoke? Yes ☐ No ☐ How old were you when you started smoking? _____

Cigarettes / Cigars How old were you when you quit? _____

How many packs per day did you/do you smoke? ☐ PPD

How long ago did you quit smoking? _____

Do you drink alcohol? Yes ☐ No ☐ How much, how often? _____

What is/was your occupation? _____

Asbestos exposure: Yes ☐ No ☐ Shift worker? Yes ☐ No ☐

Do you exercise regularly? Yes ☐ No ☐ If yes, what activity, how often? _____

Family Medical History

Father _____ If deceased, at age _____ yrs

Mother _____ If deceased, at age _____ yrs

Brothers/Sisters _____

Children _____

_____

Reviewed by: _____ ***M.D. Date*** _____