PULMONARY AND SLEEP PHYSICIANS OF HOUSTON, P.A.

PATIENT INTAKE QUESTIONNAIRE

NAME: _____ AGE _____ DATE _____

REASON FOR VISIT: _____

PAST ILLNESSES: (Check all that apply)

- ❒ Atrial Fibrillation
- ❒ Angina/Chest pain
- ❒ Asthma
- ❒ Allergies/Hay Fever
- ❒ COPD
- ❒ Blood Clots
- ☐ Emphysema
- ❒ Chronic Sinus Problems
- ❒ Cancer site _____Year:_____

Previous cancer treatments:

❒ Surgery ❒ Radiation ❒ Chemotherapy

- ❒ Diabetes
- ❒ Eye problems
- ❒ GERD (Reflux)
- ❒ Heart Attack
- ❒ Heart Failure
- ❒ High blood pressure
- ❒ Kidney Problem
- ❒ Liver Problem
- ❒ Rheumatoid Arthritis
- ❒ Pulmonary Fibrosis
- ❒ Lupus
- ❒ Skin Problems
- ❒ Stomach Ulcer
- ❒ Tuberculosis
- ❒ Thyroid Problems
- ❒ Sleep Apnea

SOCIAL HISTORY:

Tobacco:

- ❒ Never Smoked
- ❒ Active Smoker
- ❒ Ex-Smoker
- ❒ Quit Year: _____

Packs per Day Smoked _____

Recreational Drug Use? ❒ Yes ❒ No

Alcoholic Beverages:

- ❒ Never
- ❒ Less than 1 per week
- ❒ 1-5 per week
- Other:_____

OCCUPATIONAL HISTORY

Present Job: _____

❒ Full time ❒ Part Time ❒ Retired

OTHER MEDICAL PROBLEMS:

_____

_____

_____

_____

SURGERY: **DATE:**

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever worked with asbestos?

❒ Yes ❒ No

Exposed to fumes, Dust or Solvents?

❒ Yes ❒ No

MOST RECENT VACCINATIONS

- ❒ Flu Vaccine _____ (Date)
- ❒ Pneumonia _____ (Date)
- ❒ Covid _____ (Dates)

NAME: _____

FAMILY HISTORY

FAMILY MEMBER	MAJOR HEALTH PROBLEMS
Father	
Mother	
Brother/Sister	

Have either parent, brother, sister, or grandparent ever had? ❒ Tuberculsosis (TB) ❒ Lung Cancer

SYSTEMS REVIEW:

☐ Fever
☐ Night sweats
☐ Weight loss or weight gain
☐ Nasal congestion, sneezing, runny nose
☐ Post nasal drip
☐ Hoarseness
☐ Snoring
☐ Sleepiness
☐ Insomnia
☐ Loss of vision
☐ Headaches
☐ Passing out
☐ Anxiety
☐ Depression
☐ Neck pain
☐ Back pain
☐ Joint pains
☐ Shortness of breath at rest
☐ Shortness of breath walking: .....feet
☐ Shortness of breath going up one flight of stairs
☐ Shortness of breath when you lay down
☐ Shortness of breath that wakes up up at night

☐ Cough with sputum
☐ Cough, dry
☐ Coughing up blood
☐ Chest pain
☐ Palpitations
☐ Leg/ankle swelling
☐ Swallowing difficulty
☐ Heartburn
☐ Abdominal pain
☐ Nausea or vomitting
☐ Diarrhea
☐ Black stools
☐ Difficult urination
☐ Urinary incontinence
☐ Blood in urine
☐ Skin rash
☐ Weak muscles
☐ Easy bruising
☐ Easy bleeding
☐ Enlarged glands
☐ Other: .....
☐ Other: .....

NAME: _____

Patient Intake Questionnaire

MEDICATIONS	DOSE	HOW OFTEN

If list is longer than boxes provided, continue list on back of this form.

ALLERGIES TO MEDICATIONS:

_____

_____