Pulmonary Evaluation Form

Pulmonary Consultants – UPMC.
Specialists in Lung disease, Sleep Medicine and Critical Care Medicine

Name_____ DOB_____ Age_____

Referring Physician_____ PCP_____ Cardiologist_____

Briefly describe the main problem _____

_____

Do you have symptoms of:

Shortness of breath Y N
Wheezing Y N
Cough Y N
- for How long _____
Sputum production Y N
Heart Burn/GERD Y N
Cough with swallow Y N
Post Nasal Drip Y N
Sinus pain/pressure Y N
Coughing up blood Y N

Wake up at night short of breath Y N
More short of breath laying flat Y N
Chest Pain Y N
-What brings it on? _____
Joint Swelling Y N
Do your hands turn colors or get painful in cold weather Y N
Shortness of Breath Y N
If Yes, What makes you short of Breath? Other:_____
☐Walking flat ground ☐Steps How many flights?_____

Have you been exposed to?

Asbestos Y N ☐Mold
Sand Silica Bricks Y N ☐Chemicals
Animals:
Birds Y N
Dogs Y N
Cats Y N
Hot Tubs Y N
Anyone with Tuberculosis Y N

Past Medical History – Check *all that apply* to you now or in the past:

Pneumonia		Anemia		Whooping Cough	
Cystic Fibrosis/Bronchiectasis		Stroke		Bronchiectasis	
Tuberculosis		Thyroid problems		Lung Surgery	
Emphysema / COPD		Heart attack/ Heart surgery/ Stents		Prior Bronchoscopy	
Asthma		Heart Murmur/Valve disease		Other Illnesses:	
Bronchitis		Rheumatic Fever			
Cancer		Sleep Apnea			
Diabetes		GERD			
Glaucoma		Lupus/Scleroderma			
Blood Clots/ Pulmonary Embolism		Inflammatory bowel disease e.g.Crohns			

List All Surgeries or hospitalizations and dates:

Social History:

Smoking History Y N
Packs per day_____
Number of years Smoking_____
Quit? Y N When?____
Pipe,Cigars,Snuff Y N

Do you drink Alcohol? Y N
Type _____
Amount per day_____
Recreational drugs?
Second hand smoke Y N
_____

Occupation(s): List **all** including military service

List any hobbies:_____

Describe your caffeine consumption: _____

Marital Status: Single Married Divorced Widowed

Have you ever been exposed to tuberculosis? Y N Have you had a TB Skin test Y N Results: (POS / NEG)

Have you received the Pneumovax vaccine? Y N

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Allergies? (Medication or environmental)_____

Medications including inhalers and nebulizer treatments

Have you ever been on oxygen, CPAP or BiPAP?

Family History: Especially asthma emphysema, cancer, sleep apnea, heart disease blood clots

Mother: alive Y N:	Father: alive Y N:
Children: How many? Medical problems?	

Review of Symptoms. Please check all that apply to you.

Fevers		Paralysis		Join pain, redness or swelling	
Chills		Seizure; memory loss; headaches		Muscle aches or tenderness	
Sweats		Muscle weakness			
Weight loss		Stiffness		Heartburn	
Sleepiness				Indigestion	
		Unusual thoughts; nervousness		Blood in stool or dark tarry stools	
Hearing problems		Crying; sadness, depression		Abdominal pain	
Vision problems				Heartburn	
Sinus congestion		Easy bleeding			
Choking when swallowing		Anemia		Excessive thirst or hunger	
Post nasal drip		Nosebleeds		Heat or cold intolerance	
Sores in mouth					
Hoarseness		Urinary problems		Sleep walking	
Loss of smell		Blood in urine		Restless legs	
		Painful urination			

Sleep Issues:	**Yes**	**No**		**Yes**	**No**
Do you snore?			What time do you go to bed?		
Is it worse on your back?			What time do you wake up?		
Have you woken yourself up snoring?			Are you a restless sleeper?		
Do you get morning headaches?			Do you ever get drowsy at the wheel?		
Is there a family history of sleep apnea?			Do you generally wake up feeling refreshed?		
Have you gained or lost weight recently?			Are your tonsils present?		
Has anyone told you that you stop breathing when asleep?			Does anything interfere with your sleep: (noise, pain, frequent urination)		
Have you noticed and change in your skin or hair?			Are you cold when others are comfortable?		
Do you have nasal congestion or drainage or post nasal drip?			Do you awaken at night with chest discomfort, chest tightness or palpitations?		
Do you have a history of nasal polyps, trauma surgery or deviated septum?			Do you see or hear anything unusual as you are awakening or going to sleep?		
Do you ever feel that you cannot move your arms or legs as you are waking up or going to sleep?			Have you ever feel very sleepy or that you could not move during periods of extreme emotions such as happiness or sadness?		
Have you ever had "lock jaw"?			Do you have dentures? ☐upper ☐ lower		
Does anything interfere with your sleep: (noise, pain, frequent urination)					