STOCKTON PULMONARY DOCTORS
1801 E MARCH LANE, STE. C300
STOCKTON, CA 95210

PULMONARY HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Reason for Visit
Brief description of present problem/complaint: _____
_____
Have you had any chest x-rays/CT chest? _____ If so, where and when?_____

Past History – Have you ever had:							
Asthma	❑	Emphysema	❑	Bleeding Problems	❑	Stroke	❑
Tuberculosis	❑	Pneumonia	❑	Kidney Problems	❑	Ulcers	❑
Seizures	❑	Diabetes	❑	Liver Problems	❑	Arthritis	❑
Heart Attack	❑	High Blood Pressure	❑	Heart Problems	❑		
Blood Clots	❑	Cancer	❑	Thyroid Problems	❑		

Have you ever had Surgery?	
Date:	Type of surgery:
Date:	Type of surgery:
Date:	Type of surgery:
Date:	Type of surgery:

Social History
Have you ever used tobacco? Yes ❑ No ❑ If yes, what type? Cigarettes ❑ Chew ❑ Pipe ❑ Cigars ❑ #/Day:_____
How many years did you smoke? _____ When did you quit? _____
Do you drink alcoholic beverages? Yes ❑ No ❑ If yes, how many per week? _____
Have you ever used marijuana or any other illicit drug? Yes ❑ No ❑
Do you tolerate physical exercise well? Yes ❑ No ❑ Have you traveled/lived abroad? Yes ❑ No ❑
Do you have trouble sleeping? Yes ❑ No ❑ Do you have pets? Yes ❑ No ❑ What kind? _____

*** **NO PRESCRIPTIONS WILL BE REFILLED AFTER HOURS. ALL REQUESTS MUST BE DURING OFFICE HOURS ONLY** ***

List of Medications and Dosage		
1.	**5.**	**9.**
2.	**6.**	**10.**
3.	**7.**	**11.**
4.	**8.**	**12.**

Allergies
Are you allergic to any medications? Yes ❑ No ❑
Which medications? _____
Other allergies: _____

Family History				
Relationship	**Alive**	**Deceased**	**Age**	**State of Health/Cause of Death**
Mother				
Father				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Children				
Children				
Spouse/Partner				

Review of Systems – Please check all that apply					
General		**Cardiovascular**		**Musculoskeletal**	
Weight changes	❑	Chest Pain	❑	Joint Pain/Swelling	❑
Sleeping Problems	❑	Heart Attack	❑	Back Pain	❑
Loud Snoring	❑	Heart Murmur	❑	Muscle pain and aches	❑
Fevers/Chills/Sweats	❑	Palpitations	❑		
		Irregular Heart Beat	❑		
		Shortness of Breath w/ Walking	❑		
		Dizziness	❑		
		Swelling of Feet/Ankles	❑		
Respiratory		**Gastrointestinal**		**Neurological**	
Coughing	❑	Nausea/Vomiting	❑	Numbness	❑
Wheezing	❑	Vomiting Blood	❑	Tingling	❑
Shortness of breath	❑	Difficulty Swallowing	❑	Weakness/Paralysis	❑
Bronchitis	❑	Heartburn/Indigestion	❑	Tremors	❑
Frequent Colds	❑	Abdominal Pain	❑	Seizures	❑
Coughing up blood	❑	Constipation	❑		
		Diarrhea	❑		
		Bloody/Black Stools	❑		
Psychological					
Depression	❑				
Anxiety/Panic Attacks	❑				

Other Medical Problems Not Listed: _____

_____

_____

_____

Patient Signature: _____ **Date:** _____