Pinehurst Medical Clinic

NEW PATIENT QUESTIONAIRE

Pulmonary & Sleep Medicine

Date:_____

Patient Name: _____Date of Birth: _____

Referring Provider: _____

Primary Care Provider: _____

☐You are scheduled for a Pulmonary (Lung) issue with_____

☐You are scheduled for a Sleep Medicine issue with_____

What is your main lung or sleep problem?

_____

Marital status: Single Married Divorced Widow

Occupation:_____**Retired**: ☐

Education Level: _____

Leisure Activities – Hobbies: _____

_____

Medical History:

Please list current medical conditions or past illnesses ***you*** are being/have been treated for:

☐ ***I have no current diagnosed medical conditions***

☐High blood pressure	☐Diabetes	☐High Cholesterol
☐Chest pain/heart attacks	☐A-fib/Flutter	☐Congestive Heart Failure
☐Heart Valve Ds/Murmur	☐Stroke	☐Peripheral Vascular Disease
☐Pulmonary Fibrosis	☐Asthma	☐COPD ☐Emphysema
☐Pulmonary Hypertension	☐Blood Clots	☐Cancer: _____
☐Sarcoidosis	☐Heartburn/reflux	☐Allergies/Hay fever
☐Pneumonia	☐Sinus Infections ☐Ear Infections	☐Tuberculosis (TB)

☐Previously diagnosed with Sleep Apnea ☐ COVID-19

☐ If you have Sleep Apnea, are you currently using a CPAP machine? _____

Other conditions:

1.	5.
2.	6.
3.	7.
4.	8.

Surgical History: Please list any operations ***you*** have had.

☐ ***I have never had any surgeries***

☐ Gall Bladder ☐Appendix ☐Tonsils ☐Ear Tubes

☐ Heart Bypass ☐Heart Valve ☐Pacemaker/Defibrillator ☐Vascular Surgery

☐ Back ☐Hip ☐Knee ☐Shoulder

☐ Lung biopsy ☐Lung Removal ☐Bronchoscopy

Other Surgeries:

1. _____ 3. _____
2. _____ 4. _____
5. _____ 6. _____

Family History: Please check if any close ***family members*** have any of the following:

☐ Cancer ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Lung problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Heart Problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Blood Clot Problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Sleep Problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ High Blood Pressure ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Diabetes ☐Father ☐Mother ☐Siblings ☐Kids _____

Other Problems?_____Who/What: _____

Medications you are currently taking & drug dosage/frequency of each: Please include any Over-the-Counter meds.

☐ ***I'm currently not taking any prescribed medications***

☐ Albuterol (Proair, Proventil, Ventolin, Xopenex) ☐Atrovent ☐Combivent

☐ Flovent ☐Arnuity ☐Asmanex ☐Pulmicort ☐Qvar ☐Alvesco ☐Aerospan

☐ Advair ☐Breo ☐Symbicort ☐Dulera ☐ Nebulizer: _____

☐ Serevent ☐ Striverdi ☐ Arcapta ☐ Spiriva ☐ Incruse ☐ Tudorza ☐ Seebri

☐ Anoro ☐ Stiolto ☐ Bevespi ☐ Utibron ☐ Singulair ☐ Daliresp ☐ Prednisone

☐ Theophyline ☐Flonase/Nasonex ☐Claritin/Zyrtec/Allegra ☐Omeprazole/Nexium/Prilosec

Others:

1. _____ 10. _____
2. _____ 11. _____
3. _____ 12. _____
4. _____ 13. _____
5. _____ 14. _____
6. _____ 15. _____
7. _____ 16. _____
8. _____ 17. _____
9. _____ 18. _____

Allergies to Medications:

☐ ***I have no known allergies to medications***

1. _____ 3. _____
2. _____ 4. _____

Vaccinations: last given?

☐ Flu Shot: _____

☐ COVID-19: _____

☐ Pneumonia: ☐ Pneumovax (23): _____ ☐ Prevnar (13): _____

Social History

Smoking Status:

☐ Never

☐ Years Smoked:_____Age started_____Packs per day: _____

☐ Date Quit_____/_____months/years ago

☐ Lived with someone who smoked: #Years_____

Alcohol consumption: ☐None ☐Drinks per day:_____ Week:_____

Caffeine consumption: ☐None ☐Drinks per day:_____ Week: _____

Occupational History: Have you ever worked around or been exposed to the following:

☐ Asbestos: ☐ Silica or Coal dust ☐Furniture/Saw Mills

☐ Cotton or Textile Mills: ☐Welding fumes

☐ Toxic/Industrial Chemicals: _____

☐ Someone with ACTIVE tuberculosis "TB"

Current Pets: ☐Cats ☐Dogs ☐Birds ☐Other:_____

Please mark any symptoms you are having now or in the "recent" past.

General Health ☐No Symptoms

☐ Fever ☐ Malaise/no energy ☐No appetite

☐ Shaking chills ☐Fatigue ☐Drenching night Sweats

☐ Recent weight Loss

Ear Nose & Throat: ☐No Symptoms

☐ Sore throat ☐Nasal congestion ☐Ear ache

☐ Scratchy throat ☐Nasal discharge ☐Loss of hearing

☐ Hoarseness ☐Sneezing ☐White patches in mouth

☐ Nosebleeds ☐Snoring ☐Sinus pain

☐ Visual changes ☐Eye symptoms ☐Stop breathing in sleep

Cardiovascular: ☐No Symptoms

☐ Chest Pain ☐Racing heart ☐Leg Edema

☐ Palpitations ☐Light headedness

Pulmonary: ☐**No Symptoms**

☐Short of breath (SOB)	☐Cough	☐Clear sputum
☐Wheeze	☐Dry cough	☐Colored sputum
☐Productive cough	☐Coughing up blood	☐SOB worse lying down
☐Unable to cough up sputum	☐Coughing when eating	☐Chest pain with breathing
☐Sleeping upright/Extra pillows	☐Awakening at night SOB	

Gastrointestinal - Stomach & Bowels: ☐**No Symptoms**

☐Abdominal Pain	☐Nausea	☐Constipation
☐Abdominal bloating	☐Vomiting	☐Bright Red Blood per Rectum
☐Abdominal cramps	☐Diarrhea	☐Melena/black-sticky stool
☐Menstrual pain	☐Heartburn	☐Vomiting blood
☐Unable to pass flatus		

Urinary: ☐**No Symptoms**

☐Painful urination	☐Suprapubic pain
☐Urinary frequency	☐Pelvic pain
☐Urinary urgency	☐Dark urine
☐Flank pain	☐Blood in urine

Female Specific

☐Foul smelling vaginal d/c
☐Missed menstrual period
☐Suspected pregnancy
☐Menstrual pain

Male Specific

☐Urinary incontinence
☐Urinary hesitancy
☐Nocturia
☐Testicular pain

Musculoskeletal: ☐**No Symptoms**

☐Diffuse joint pain	☐Joint swelling	☐Pain in other joints
☐Muscle ache generalized	☐Joint stiffness	☐Limping
☐Back pain	☐Back muscle spasm	

Skin & Breasts: ☐**No Symptoms**

☐Rash	☐Erythema	☐Nodule
☐Lesions	☐Edema	☐Plaque
☐Wound	☐Scaling	☐Papule
☐Itching	☐Blister	☐Pustule
☐Ulcer	☐Breast pain	☐Pain w/o rash or sore
☐Mouth sores	☐Patch	☐Breast lump

Neurologic: ☐**No Symptoms**

☐Headache	☐Paresthesia/pins & needles	☐Leg Weakness	☐Fainting
☐Confusion	☐Saddle paresthesia	☐Tingling	
☐Dizziness	☐Leg numbness	☐Difficulty walking	

IMPORTANT

If you've had **CT Scans** and/or **Chest X-rays** please bring the CD-ROM disk to your appointment.

You will not need the disk if you had these done at the following:

FirstHealth of the Carolina – all hospitals and clinic locations
Scotland Memorial Hospital
Pinehurst Medical Clinic
Pinehurst Surgical Clinic
Valley Regional Imaging

Sleep Questionnaire

Do you snore? ☐Yes ☐No ☐Don't know

If yes, is it loud? ☐Yes ☐No ☐Don't know

How long ago did it start?_____ months/years

Is it worsening? ☐Yes ☐No ☐Don't know

In which positions do you snore? ☐ Back only ☐ All positions

Is your snoring worse on your back? ☐ Yes ☐No ☐ Don't know

Do you snore if you fall asleep in a chair? ☐ Yes ☐No ☐ Don't know

Does your snoring disturb anyone? ☐ Yes ☐No Who? _____

Has anyone ever noticed if you stop breathing in your sleep? ☐Yes ☐No

Do you ever wake yourself from sleep with your snoring, gasps or feeling choked? ☐Yes ☐No

Do you suffer from either of the following in the morning? ☐Dry mouth ☐Headaches ☐Neither

Do you feel sleepy during the daytime? ☐Yes ☐No

If yes, how many days per week? _____

When did it start?_____months/years

Is it worsening? ☐Yes ☐No ☐ Don't know

Have you ever felt sudden loss of strength in response to emotional experiences? ☐Yes ☐NoHave you ever felt paralyzed when you first wake up or when falling asleep? ☐Yes ☐No

Have you ever had vivid or menacing visions just before falling asleep? ☐Yes ☐No

Do you walk in your sleep? ☐Yes ☐No ☐Don't know

Do you talk in your sleep? ☐Yes ☐No ☐Don't know

Do you have nightmares? ☐Yes ☐No

Do you ever accidentally urinate in bed? ☐Yes ☐No

What time do you generally go to bed?_____pm/am Wake up?_____am/pm

How long does it usually take for you to fall asleep?_____minutes?_____hours?

How many times do you wake up in the middle of the night? _____

Are you able to fall back to sleep easily after these night awakenings? ☐Yes ☐No ☐Not always

EPWORTH Sleepiness Scale: Please rate your ***chance of dozing*** in following situations.

0 – NEVER dose

1 – SLIGHT chance

2 – MODERATE chance

3 – HIGH chance

____ Sitting & reading

____ Watching TV

____ Sitting inactive in public

____ Passenger in a car w/o break

____ Laying down to rest in afternoon

____ Sitting & talking to someone

____ Sitting quietly after lunch w/o alcohol

____ In a car, stopped in traffic for a few minutes

Have you ever had a traffic accident or "close call" while driving because of sleepiness?

☐Yes ☐No

Do you suffer from memory problems? ☐Yes ☐No

Do you take any daytime naps? ☐Yes ☐No

How many per week?_____How long do you nap on average?_____Minutes

Are the naps refreshing? ☐Yes ☐No

Rate the severity of your daytime sleepiness on a scale of 1 to 10. _____

Do you ever experience restlessness or discomfort in your legs, especially in the evenings? ☐Yes ☐No

Does it interfere with sleep? ☐Yes ☐No

Do you move or kick your legs while sleeping? ☐Yes ☐No ☐ don't know

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IMPORTANT

If you had a **Sleep Study** at another facility, **please bring copies of the study** with you or have reports faxed to:

Fayetteville (910) 420-1618 Pinehurst (910) 235-3401 Sanford (919) 292-1205