Pinehurst Medical Clinic, Inc.

NEW PATIENT QUESTIONAIRE
Pulmonary & Sleep Medicine

Date: _____

Patient Name: _____

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

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

Other conditions:

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

Pinehurst Medical Clinic, Inc.

NEW PATIENT QUESTIONAIRE
Pulmonary & Sleep Medicine

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: 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. _____

Pinehurst Medical Clinic, Inc.

NEW PATIENT QUESTIONAIRE
Pulmonary & Sleep Medicine

Allergies to Medications:
☐ ***I have no known allergies to medications***

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

Vaccinations: last given?
☐Flu Shot: _____
☐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

Pinehurst Medical Clinic, Inc.

NEW PATIENT QUESTIONAIRE
Pulmonary & Sleep Medicine

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 ☐No

Have 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

---

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