Pike Medical Consultants

Pulmonary History Questionnaire

Appointment Date:_____ Appointment Time:_____

Like most physician groups, our practice uses a history form for first-time patients. We have designed this questionnaire for the specifics of our practice. This form should serve three functions:

1. Act as a checklist to make certain that important questions are always asked
2. Improve the quality of the history by giving you time to recall important details
3. Save time during the office visit

Do not be put off by the apparent length of the questionnaire. There is a lot of empty space for the doctor to write in. Also, you will probably be able to skip some portions of the form. We hope you will find the form to be self-explanatory. If there is a question that you do not understand, please leave it blank and put a question mark in the left-hand margin.

PLEASE BRING:

- **Insurance cards and a photo ID.**
- **All forms attached to this coversheet filled out to the best of your ability.**
- **All CD's/films from chest x-rays/CT scans.** (Applies to Abnormal lung finding patients only.)
- **A current list of medications** (including dose and frequency). Remember to include insulin, inhalers, eye drops, vitamins, and herbal supplements.

YOU MAY BE ASKED TO RESCHEDULE IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR <u>ARRIVAL</u> TIME. If your insurance policy has an office visit co-pay, it will be collected upon registration. We accept cash and credit/debit cards with a Visa, MasterCard, or Discover logo.

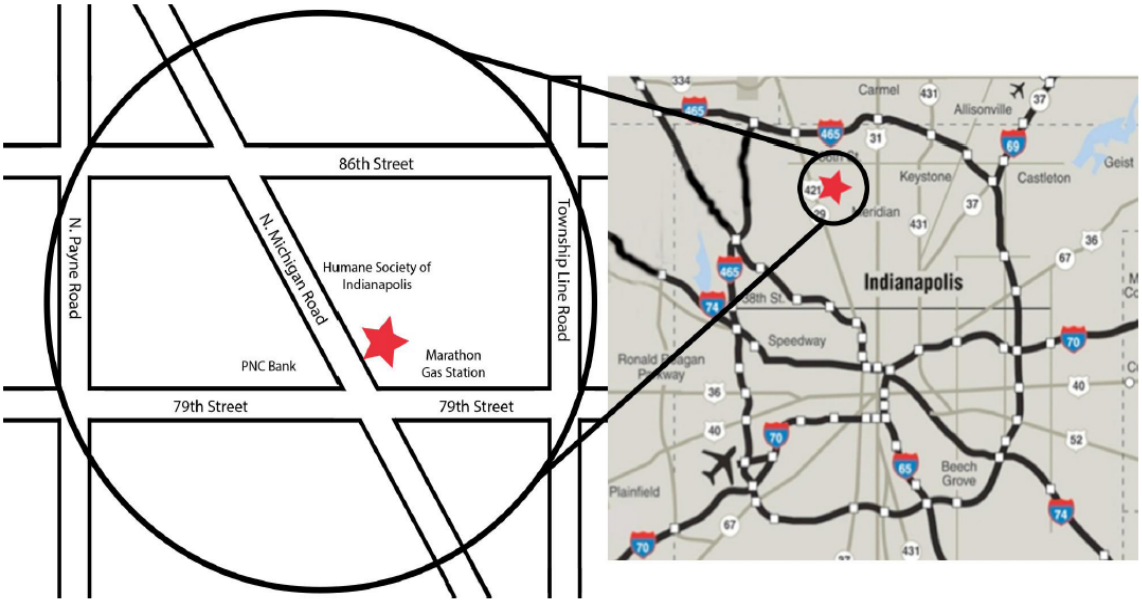
If you have any questions, please call our office between the hours of 9am and 4pm.

Pike Medical Consultants

UrgentCare Indy | WeightCare Indy | GeriCare Indy

PULMONARY | OCCUPATIONAL HEALTH | COUNSELING SERVICES

7911 N. Michigan Road Indianapolis, IN 46268 | 317.956.6288 | pikemedical.com



If North of Indianapolis	If South of Indianapolis	If East of Indianapolis	If West of Indianapolis
- Take I-65 South - Merge onto I-865 E - Merge onto I-465 S - Take exit 27, Michigan Road - Turn right off the exit ramp - Continue on Michigan Road/US-421 N. - Destination is on the left just before 79th street	- Take I-74 West to I-65 North - Take exit 116 toward 30th St. - Merge onto W. 30th St. via the ramp on the left toward Indianapolis Museum of Art/Butler Univ. - Turn right onto Martin Luther King Jr. St. This becomes Michigan Rd. - Destination is on the right	- Take I-70 W or 69 S - Merge to 65 N. via exit 83B - Take exit 116 toward 30th St. - Merge onto W. 30th St. via the ramp on the left toward Indianapolis Museum of Art/Butler Univ. - Turn right onto Martin Luther King Jr. St. This becomes Michigan Rd. - Destination is on the right	- Take US I-70 or I-74 East - Merge onto I-465 N - Take exit 21 onto 71st St. - Keep left to take the 71st St. ramp - Turn right onto 71st St. - Turn left onto Michigan Road - Destination is on the right

YOUR NAME: _____
First Middle Last

DATE OF BIRTH: _____ **AGE (How old are you today?):** _____

OTHER PHYSICIANS YOU'VE SEEN:

What is the name of the physician who referred you? _____

Where does this referring physician practice?

☐ Indianapolis ☐ Other City: _____

Is the referring physician your **primary doctor** (the physician you see for your routine medical care)?

☐ YES

☐ NO If NO, What is your primary doctor's name? _____

Where is your primary doctor's office located? _____

Are there other doctors, not listed above, that you see on a regular basis who might be interested in knowing about the problem that brings you here?

☐ YES

☐ NO

If YES, please list these doctors' names and practice locations:

Name: _____ Location: _____

Name: _____ Location: _____

Name: _____ Location: _____

WHY HAVE YOU COME TO SEE US?

Please list the reason(s), symptom(s), or problem(s) that have led you to come here. List the most important reason first.

1. _____

2. _____

3. _____

TOBACCO USE HISTORY

Have you ever smoked cigarettes, cigars, pipes, or chew tobacco?

☐ NO If NO, please skip to "**WORK HISTORY"**

☐ YES If YES, at what age did you first start using tobacco products? _____

Are you still using tobacco products?

☐ NO If NO, at what age did you quit using tobacco products? _____

☐ YES If YES, please skip to the next question

How many packs of cigarettes ON AVERAGRE do (or did) you use each day? (Please circle the number closest to your average.)

½ 1 1 ½ 2 2 ½ 3 3 ½ 3 ½ 4

WORK HISTORY

Have you ever been employed outside of the home?

☐ NO If NO, please skip to "**RESPIRATORY SYSTEM REVIEW**"

☐ YES If YES, please skip to the next question.

Are you still working?

☐ NO If NO, in what year did you last work? _____

☐ YES If YES, what type of work have you done most recently? _____

Have you ever worked in any of the following work fields? (Please check all that apply)

☐ Farming
☐ Foundry
☐ Metal Working
☐ Mining
☐ Plumbing
☐ Popcorn Manufacturing
☐ Stone Quarry
☐ Welding

Have you ever worked with or been exposed to the following: (Please check all that apply)

☐ Asbestos
☐ Beryllium
☐ Moldy Wheat or Wheat Dust

RESPIRATORY SYSTEM REVIEW

Shortness of Breath

Do you experience shortness of breath when you walk or exert yourself?

☐ NO
☐ YES

If YES, please review the options below and check the lowest level of exertion which causes uncomfortable breathing:

☐ No activity required (shortness of breath while at rest)
☐ Very little exertion (getting dressed)
☐ Little exertion (walking from room to room)
☐ Moderate exertion (making a bed or walking a block)
☐ Moderate heavy exertion (climbing two flights of stairs)
☐ Heavy exertion (walking quickly up a long hill)

Shortness of Breath during Sleep or Lying Down

Do you awaken from sleep during the night because of shortness of breath?

☐ NO
☐ YES

If YES, how frequently does this happen? _____

What seems to relieve your breathing after awakening with shortness of breath?

☐ Using my inhaled medications
☐ Sitting or standing up
☐ Letting time pass
☐ Other: _____

Do you get short of breath if you lie down flat?

☐ NO

☐ YES If YES, at what angle do you have to sleep to be comfortable?

☐ 15°	☐ 30°	☐ 45°	☐ 60°	☐ 90°
				

Sensitivity to Inhaled Materials

Is there anything that you have been around or inhaled that seems to make you wheeze, cough, or become short of breath?

☐ NO

☐ YES If YES, please check all items that bother you:

☐ Aerosol Sprays
☐ Cigarette smoke
☐ Colognes, perfumes
☐ Solvents
☐ Cleaning compounds
☐ Cold, dry air
☐ Hot, humid air
☐ Dogs
☐ Cats
☐ Trees
☐ Grass
☐ Ragweed
☐ House dust
☐ Molds or mildew\

Cough

Do you have some type of cough most days?

☐ NO If NO, please skip to **"Additional History"**:

☐ YES

Do you cough up any mucus, phlegm, or sputum?

☐ NO If NO, please skip to **"Additional History"**:

☐ YES

What color is the sputum most often?

☐ Clear, white, or foamy
☐ Yellow
☐ Green
☐ Other: _____

Approximately, how much sputum do you usually cough up in the course of a 24-hour day?
(Please provide your best estimate)

☐ 1 Teaspoon (5 cc/s)
☐ 1 Tablespoon (15 cc/s)
☐ 1 Ounce (30 cc/s)
☐ ¼ Cup (60 cc/s)
☐ ½ Cup (120 cc/s)
☐ 1 Cup (240 cc/s)

Additional History

Have you ever coughed up any blood?

☐ NO

☐ YES

Have you ever been exposed to tuberculosis?

☐ NO

☐ UNCERTAIN

☐ YES If YES, when? _____

How you ever had a skin test for tuberculosis?

☐ NO
☐ YES

If YES, when was your most recent skin test? _____

Have any of the skin tests been positive?

☐ NO
☐ YES If YES, when? _____

Are you bothered by pain in your chest?

☐ NO
☐ YES

Are you often bothered by a 'runny' or 'stuffy' nose?

☐ NO
☐ YES

Do you think you have 'postnasal drip'?

☐ NO
☐ YES

Do you have problems with heartburn?

☐ NO
☐ YES

Do you ever awaken at night with 'sour brash' (acid, bitter-tasting stomach contents) in your throat or mouth?

☐ NO
☐ YES

MEDICATION ALLERGIES AND SENSITIVITIES

Has aspirin ever seemed to bother your breathing?

☐ NO
☐ YES
☐ UNCERTAIN

Have you had problems with reactions to other medications?

☐ NO If NO, please skip to **"Past Medical History"**
☐ YES If YES, please list any medication which have bothered you, as well as the reaction you had to the drug (rash, trouble breathing, nausea, etc)

DRUG	RECATION	DRUG	RECATION

MEDICATIONS

It is important for us to know about ALL of the medications you are taking. Non-prescription medication may be just as important as prescription medication. Please list the medication NAME, DOSE (amount taken in mg, puffs cc/s, units, etc.), and the FREQUENCY at which you take your medication (once a day, every 8 hours, etc.). List all medicines regardless of the route of administration (this includes those taken by mouth, inhalation, injections, skin patches, sprays, and drops).

MEDICATION NAME	DOSE	FREQUENCY

Oxygen at home: _____ liters/minute flow

PAST MEDICAL HISTORY

Surgeries

Have you ever had any surgeries or operations?

☐ NO If NO, please skip to **"Medical Hospitalizations"**

☐ YES If YES, please list the hospitalizations below, with approximate dates. (Be particularly to list any surgery involving nose, sinuses, throat, neck, chest, heart, or lung).

SURGERY	DATE

Medical Hospitalizations

☐ NO If NO, please skip to **"Other Medical Problems"**

☐ YES If YES, please list, on the top of the next page with approximate dates, your hospitalizations. (Be particularly carefully to list all hospitalizations for heart attacks, blood clots, pneumonia, bronchitis, and asthma).

HOSPITALIZATION DATE

Other Medical Problems

Have you ever been diagnosed with one of the following?
(Please check all which apply and include the date when the problem was first noted).

☐ Cancer _____ ☐ High Blood Pressure _____

☐ Diabetes _____ ☐ Liver Disease _____

☐ Heart Disease _____ ☐ Thyroid Disease _____

If you have had other serious medical problems that are not mentioned elsewhere, please list them below with the date the problem was first noted:

CONDITION DATE CONDITION DATE

Immunizations

Have you ever had a pneumonia shot (pneumococcal vaccine)?

☐ NO
☐ UNCERTAIN
☐ YES If YES, in what year? _____

Have you ever had a flu shot (influenza vaccine) within the last 9 months?

☐ NO
☐ UNCERTAIN
☐ YES

SOCIAL LIFE/HABITS

Current Marital Status

☐ Never Married ☐ Divorced

☐ Married ☐ Widowed

Do you live alone?

☐ NO
☐ YES

Have you traveled outside of the state of Indiana within the last year?

☐ NO
☐ YES

Do you ever drink alcoholic beverages?

☐ NO
☐ YES If YES, how many ounces (or shots, cans, glasses) and with what frequency (per day, week, or month) do you consume alcoholic beverages? _____

Are you currently using any 'recreational drugs' like marijuana, cocaine, etc?

- ☐ NO
- ☐ YES

Do you have any pets?

- ☐ NO
- ☐ YES If YES, please check all that apply:
  - ☐ Birds (including pigeons)
  - ☐ Cats
  - ☐ Dogs
  - ☐ Other: _____

List all of your hobbies that may expose you to fumes or dust: (This includes painting, woodworking, ceramics, etc.)

_____

_____

_____

FAMILY HISTORY

Please check all of the following conditions that any one of your close blood relatives have experienced:

- ☐ Asthma
- ☐ Allergies/Hay Fever
- ☐ Auto-immune diseases (lupus, rheumatoid arthritis, etc.)
- ☐ Diabetes
- ☐ Cystic Fibrosis

GENERAL SYSTEMS REVIEW

Are you currently having problems with any of the following? (Please check all that apply)

- ☐ Weight change of more than 5lb over the past 6 months
- ☐ Fever, shaking, chills, and/or sweats
- ☐ Easy fatigue or lack of energy
- ☐ Eyes (blurriness, double vision, etc.)
- ☐ Ears or hearing problems
- ☐ Dental abscesses or periodontal disease
- ☐ Trouble swallowing
- ☐ Irregular/fast heartbeat
- ☐ Numbness or weakness
- ☐ Abdominal pain, nausea, vomiting, bowel problems
- ☐ Bladder or kidney problems
- ☐ Swelling
- ☐ Depression or anxiety
- ☐ Bleeding which does not stop normally

The doctor will be asking you additional questions about any presenting symptoms or problems as well as some of the other problems you have indicated on this form. If there is anything not listed above that you would like the doctor to know about yourself or your general medical history please mention the issue(s) during your office visit and be prepared to discuss them.

THANK YOU FOR COMPLETING THE HISTORY QUESTIONNAIRE!

PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT **PATIENT REGISTRATION**

Patient Information

First Name	Middle Initial(s)	Last Name	
Street Address	City	State	Zip Code
Date of Birth	Primary Phone Number	Secondary Phone Number	
Social Security Number	□ Male □ Female	Email Address	
What is your preferred method of contact? □ Phone □ Email		May we leave a message? □ Yes □ No	
Marital Status □ Single □ Married □ Divorced □ Widowed		Preferred Language □ English □ Spanish □ Other:	
Race □ Asian □ Black or African American □ Native American □ White □ Other:		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino	
Current Employer or Employment Status	City	State	Phone Number
How did you hear about us: □ Physician Referral □ Internet: Google/Bing/Yahoo □ Word of Mouth □ 86th Street Sign □ KLOVE □ Other:			
Emergency Contact Name		Phone Number	Relation to Patient
Family Physician Name	Physician Phone Number	Preferred Pharmacy	Pharmacy Phone Number
If necessary, may we verify your prescriptions with pharmacy records? □ Yes □ No			

Current Billing Information

Responsible Party's Name □ Self		Relationship to Patient	Date of Birth
Street Address		City	State / Zip Code
□ I do not currently have medical insurance (check box and skip to signature line)			
Primary Insurance Company		Group Number	Policy/ID Number
Policy Holder's Name	Date of Birth	Social Security Number	Relation to Patient
Employer	City, State and Zip Code		Phone Number
Secondary Insurance Company		Group Number	Policy/ID Number
Policy Holder's Name	Date of Birth	Social Security Number	Relation to Patient
Employer	City, State and Zip Code		Phone Number
Prescription Plan Name (if applicable)	Prescription Plan ID Number		Contact Number

Authorization and Assignment

(APPLIES TO MEDICARE PATIENTS ONLY) I request that payment of authorized MEDICARE benefits be made either by me or on my behalf to provide for any services furnished to me by a medical provider. I authorize the holder of my medical information to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

(APPLIES TO MEDIGAP PATIENTS ONLY) I request that payment of authorized MEDIGAP benefits be made either by me or on my behalf to provide for any services furnished to me by a medical provider. I authorize any holder of medical information about me to release to my MEDIGAP insurance any information needed to determine these benefits payable for related services.

ALL PATIENTS/GUARANTORS: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to the medical provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. If for any reason my account should become delinquent, I agree to pay for all collection and legal fees. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain valid until revoked by me or my legal representative.

Signature of Responsible Party **Today's Date** **v11/13**