CAPA

Capitol Area Pulmonary Associates
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NEW PATIENT QUESTIONNAIRE, Pulmonary Medicine

Patient Name: Date of Birth: _____ , Age:

What brings you to our office today? Cough: dyspnea: wheezing: abnormal x ray:

Others:

How long have you had this problem?

_____

_____

what causes your breathing problem to worsen: _____

_____

When did you first seek medical attention for this problem? _____

Have you seen a lung doctor in the past? If yes, who? when?

Have you had breathing tests in the past? If yes, when? where? _____

Have you had a chest X-ray or CT Scan of chest?_____ If yes, when?_____ where?

_____

PAST MEDICAL HISTORY

❑ COPD	❑ Emphysema	❑ Asthma
❑ Pulmonary embolism (blood clots in lungs)	❑ DVT (blood clots in legs)	❑ Pulmonary Hypertension
❑ Lung cancer	❑ Other cancer _____	❑ Pulmonary fibrosis
❑ Pleural effusion (Fluid around lungs)	❑ Pneumothorax	❑ Diabetes
❑ High Blood pressure	❑ Hypothyroidism	❑ Congestive Heart failure
❑ Coronary artery disease	❑ Sleep apnea	❑ Osteoarthritis

❑ Other chronic medical conditions

_____

❑ Hospitalization for respiratory problems

PAST SURGICAL HISTORY

❑ Lung surgery ❑ CABG (bypass surgery) ❑ Heart valve replacement

❑ Cholecystectomy (gall bladder removal) ❑ Pacemaker/ICD placement ❑ IVC filter placement

❑ Other surgeries _____

Immunization Up to date:

	YES	**NO**	**When?**
Pnuemonia vaccine			
Prevnae13			
Influenza			

FAMILY HISTORY

	What type:	Which family member	when
Any cancer			
COPD			
tuberculosis			
Blood clots			

SOCIAL HISTORY

Do you smoke? _____ Have you ever smoked?_____If yes, how many packs per day? _____

How many years have you been smoking?_____ If you no longer smoke, when did you quit?_____

How many years did you smoke before you quit?_____Does anyone in your house smoke? ____

Do you drink alcohol? If yes, how often?

Do you use street drugs? If yes, how often?

What is/was your occupation? Were you exposed o any chemicals , fumes or asbestos? if yes, What?_____

Military history?_____Exercise history:?_____PETS:?_____

REVIEW OF SYSTEMS

	Yes	No	MUSCULOSKELETAL	Yes	No
GENERAL			Joint pain		
Recent weight gain > 10 lbs			Back pain		
Recent weight loss > 10 lbs			Joint swelling		
Fatigue			Muscle weakness		
Fever			Muscle pain		
Night sweats					
			NERVOUS SYSTEM		
EARS, NOSE, MOUTH, THROAT			Headaches		
Ringing in ears			Dizziness		
Loss of hearing			Weakness		
Frequent sore throats			Numbness or tingling		
Hoarseness			Memory loss		
Sinusitis					
			ENDOCRINE		
RESPIRATORY			Polydipsia (excessive thirst)		
Shortness of breath			Loss of appetite		
Chronic cough			Heat intolerance		
Hemoptysis (coughing up blood)			Cole intolerance		
Wheezing			Goiter		
Pleurisy					
			GASTROINTESTINAL		
CARDIOVASCULAR			Vomiting		
Chest pain			Heartburn		
Palpitations			Abdominal pain		
Edema (swelling in legs/feet)			Diarrhea		
Syncope (passing out)			Blood in stool		
Shortness of breath at night					

ALLERGIES ❑ **NO KNOWN DRUG ALLERGIES**

❑ Medications ❑ None ❑ Yes _____

❑ Food ❑ None ❑ Yes _____

❑ Other / Environmental ❑ None ❑ Yes_____

Patient Name: _____ Date of Birth: _____

Yes	**No**	**Do you snore loudly (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?**
Yes	**No**	**Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone)?**
Yes	**No**	**Has anyone observed you stop breathing or choking/gasping during your sleep?**
Yes	**No**	**Do you have or are being treated for high blood pressure?**
Yes	**No**	**Body mass index more than 35 kg/m2?**
Yes	**No**	**Age older than 50 years old?**
Yes	**No**	**Is your shirt collar 16 inches or larger?**
Yes	**No**	**Gender (biologic sex) = Male?**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Please circle the most appropriate answer using the following scale.

0 = never	1 = occasionally	2 = often	3 = usually

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
At a public place like a theater or meeting	0	1	2	3
While a passenger in a car for one hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting down after lunch	0	1	2	3
Stopped at a stoplight	0	1	2	3

Total score out of 24:_____*(please add)*

Patient Name: _____ Date of Birth: _____

MEDICATION LIST (Please include all medications including inhalers, over the counter, and vitamins that you are currently taking)

Name	DOSE	Direction	When was started

Patient Name: _____ Date of Birth: _____