Beth Israel Deaconess
Medical Center
Boston, MA 02215

PULMONARY MEDICINE
NEW PATIENT QUESTIONNAIRE

Reason for today's visit: ______________________________

Primary care physician (PCP): ______________________________

Address of PCP if outside of BIDMC: ______________________________

Referring physician (if different from Primary Care Physician): ______________________________

Have you had any of the following? Please give dates if possible.			
I. Pulmonary History:	No	Yes	Please provide details below
Asthma			
Seasonal Allergies / Hay fever / Eczema			
Pneumonia			
Bronchitis / Sinusitis			
Bronchiectasis			
Abnormal chest X-ray or CT scan			
Tuberculosis / Exposure to TB			
Exposure to asbestos			
Blood clots in the legs or in the lungs			
Emphysema / Chronic Bronchitis			
Respiratory failure (on a ventilator)			
Sleep Apnea			
Lung Cancer			
Wheezing			
Chest congestion or tightness			
Cough			
Sputum (phlegm) and its color			
Coughing up blood			
Shortness of breath while moving or lying flat			
Waking up at night with shortness of breath			
Swelling of ankles or legs			
Other pulmonary (lung) symptoms or diagnosis			
Have you had a flu vaccine within the past year?			Date: ____/____/____
Pneumococcal (pneumonia) Vaccine within the past 10 yrs?			Date: ____/____/____
II. Past Medical History:			
Hypertension (high blood pressure)			
High cholesterol			
Heart disease			
Cancer			
Diabetes			
Thyroid disease			
Rheumatoid arthritis or Osteoarthritis			
Other arthritic or connective tissue disorder			

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II. Past Medical History (*Continued*):	**No**	**Yes**	Please provide details below
Kidney disease			
Immunosuppression of any cause			
Gastrointestinal (gut) or Liver disease			
Neurologic disease			
Other: ______			
III. Past Surgical History:			
Lung Surgery			
Heart Surgery			
Other Surgery: ______			
IV. Family History: Please indicate if any close relatives have had any of the following.			If possible, tell the age when the disease was diagnosed.
Asthma / Wheezing			
Seasonal Allergies / Eczema			
Tuberculosis			
Blood clots in legs or in lungs			
Emphysema / Chronic Bronchitis			
Sleep Apnea			
Heart Disease			
Cancer			
Other: ______			

V. Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow / Widower

Who lives at home with you? ______ Do you have pets: ☐ No ☐ Yes

Are you currently working: ☐ No ☐ Yes ***If Yes,*** occupation: ______

Do you currently smoke? ☐ No ☐ Yes

If Yes, how many years: ______ How many packs/day on average? ______

If you don't smoke now, did you ever smoke? ☐ No ☐ Yes: Year you quit: ______

VI. Review of Symptoms: Have you had any of the following symptoms **recently**?	**No**	**Yes**	Please describe and tell how long you have had the symptoms.
Fever			
Chills			
Sweats			
Weight loss / gain			
Fatigue			
Snoring			
Daytime sleepiness			
Insomnia			

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PULMONARY MEDICINE
NEW PATIENT QUESTIONNAIRE

VI. Review of Symptoms (*Continued*): Have you had any of the following symptoms **recently**?	No	Yes	Please describe and tell how long you have had the symptoms.
Restless legs			
Nasal or sinus congestion			
Runny nose or post nasal drip			
Nose bleeds			
Sore throat or hoarseness			
Loose teeth or dentures			
Chest pain or tightness			
Leg pain when moving			
Swelling of ankles or legs			
Palpitations (fast heart beat or skipped beats)			
Fainting spells			
Nausea or vomiting			
Heartburn or sour taste in mouth			
Difficult or painful swallowing			
Abdominal (belly) pain or tenderness			
Easy bruising or bleeding			
Anemia (low red blood cell counts)			
Enlarged or painful lymph glands			
Musculoskeletal (muscle or bone) pain			
Painful or swollen joints			
Cannot tolerate heat or cold			
A lot of thirst			
Urinary Problems			
Rash			
Itching or hives			
Muscle weakness			
Numbness in the arms or legs			
Feelings of depression or anxiety			
Other: ______________________			

Patient Certification: I have answered these questions to the best of my ability. I understand that this information will be used to guide my care.

X______________________________ ______________________________ **OR**

Patient's Signature — Print Name

X______________________________ ______________________________ and ______________________

Signature of Person authorized to sign for patient — Print Name — Relationship to patient

Date: ___/___/___ Time: ___ ___ : ___ ___ ○ a.m. ○ p.m.

Physician Review: I have reviewed this information with the patient and/or the patient's representative.

X______________________________M.D. ______________________________M.D. ___/___/___ ___ ___ ___ ___

Physician Signature — Print Name — Date — Time (24 hour)

Name of Interpreter (if applicable):______________________________

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PATIENT NOTES
Pulmonary Medicine

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Prohibited Abbreviation	Preferred Term	Prohibited Abbreviation	Preferred Term
MS or MSO_4	*Write* Morphine Sulfate	ug	*Write* mcg or Microgram
$MgSO_4$	*Write* Magnesium Sulfate	QD or q.d.	*Write* Daily or Once Daily
Trailing Zeros (*e.g.* 5.0)	*Write* 5 Do not use zero after decimal	QOD	*Write* Every Other Day
Leading Zeros (*e.g.* .5)	*Write* 0.5 Use a zero before a decimal	d	*Write* Days or Doses
U (for Unit)	*Write* Unit	TIW or tiw	*Specify which three days of the week*
IU	*Write* Unit *or* International Unit		

NOTE: Each entry must be dated and legible with the author clearly identified, including title and pager ID

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