MOUNT SINAI - NATIONAL JEWISH HEALTH

Respiratory Institute

Icahn School of Medicine at Mount Sinai

National Jewish Health®

Patient Name: _____

Date of Birth: _____

Cell Phone: (_____) _____

ADULT PATIENT QUESTIONNAIRE

Today's Date: _____/_____/_____

Your Cell Phone: (_____)_____

Emergency Contact Name: _____

Emergency Contact Phone: (_____)_____

Physician and Pharmacy Information

(Please check the box next to your referring physician.)

○ **Primary Care Physician (Family Practice, Internist)**

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

○ **Physician #2 (Pulmonology, Allergy, Cardiology, GI)**

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

○ **Physician #3 (Pulmonology, Allergy, Cardiology, GI)**

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

○ **Physician #4 (Renal, Rheumatology, ID, Other)**

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

Preferred Retail Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Mail Order/Alternate Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Medical History: What would you like to talk about during your visit?

_____

_____

Medications Taken Regularly

Include all herbal medications, supplements, vitamins and over-the-counter medications. If needed, please provide a separate list.

	Medication Name	Dose	Route (Oral, Inhale)	How Often?
ex	*Lipitor*	*10 mg*	*oral*	*Once daily*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Allergies

Allergic to: ☐ IV Contrast Dye: Type_____ ☐ Penicillin: Type_____

Please list food, medication or insect allergies	Describe reaction

Oxygen and Respiratory Equipment

1. Do you use oxygen? ☐ Yes ☐ No
   Amount: _____ ☐ Nasal Cannula ☐ Mask ☐ Transtracheal
2. Do you use a ☐ CPAP or ☐ Bi-PAP Settings:_____
3. What company delivers your oxygen or other medical equipment? _____

Past Medical History: Do you have any of the following?

Allergies/Immunology

Allergies	☐ Yes	☐ No
AIDS	☐ Yes	☐ No
Allergic Rhinitis	☐ Yes	☐ No
Combined immunity deficiency	☐ Yes	☐ No

Infectious Disease

Hepatitis	☐ Yes	☐ No
Tuberculosis (**if yes, describe below**)	☐ Yes	☐ No
Mycobacterial Infection	☐ Yes	☐ No
HIV	☐ Yes	☐ No

Kidney/Urinary/Renal

Renal Insufficiency	☐ Yes	☐ No
Chronic Renal failure	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No

Mental Health

Anxiety Disorder	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No

Neurology

Alzheimer's Disease	☐ Yes	☐ No
Amyotrophic Lateral Sclerosis	☐ Yes	☐ No
Myasthenia Gravis	☐ Yes	☐ No
Parkinson's Disease	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No

Blood

Gout	☐ Yes	☐ No
Hemochromatosis	☐ Yes	☐ No
Thrombocytopenia	☐ Yes	☐ No
Thrombophilia	☐ Yes	☐ No
Anemia, iron deficiency	☐ Yes	☐ No
Anemia, sickle cell	☐ Yes	☐ No

Ophthalmology

Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

RESPIRATORY (**if yes, describe below**)

Obstructive Sleep Apnea	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bronchiectasis	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
DVT or Pulmonary Embolism	☐ Yes	☐ No
Narcolepsy	☐ Yes	☐ No
Pulmonary Artery Hypertension	☐ Yes	☐ No
Pulmonary Fibrosis	☐ Yes	☐ No
Sarcoidosis	☐ Yes	☐ No

Rheumatology

Ankylosing Spondylitis	☐ Yes	☐ No
Lupus/SLE	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No
Sjogren's Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No

Cancer (if yes, describe below)

Lung Cancer	☐ Yes	☐ No
Chemotherapy (**if yes, state when below**)	☐ Yes	☐ No
Radiation Therapy (**if yes, describe below**)	☐ Yes	☐ No

Cardiovascular

Aortic valve disorders	☐ Yes	☐ No
Myocardial infarction	☐ Yes	☐ No
Mitral valve disorder	☐ Yes	☐ No
Peripheral vascular Disease	☐ Yes	☐ No
Atrial fibrillation	☐ Yes	☐ No
Cardiomyopathy/CHF	☐ Yes	☐ No
Claudication	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No

Dermatology

Psoriasis	☐ Yes	☐ No
Acne	☐ Yes	☐ No

Endocrine

Adrenal gland disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No

ENT

Chronic sinusitis	☐ Yes	☐ No
Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No

Gastrointestinal

GERD (reflux problems)	☐ Yes	☐ No
Peptic ulcer disease	☐ Yes	☐ No
Esophageal Dysfunction	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Ulcerative Colitis	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No
Gallstones/Cholecystitis	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No

Genetics

Congenital Heart Defects	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No

Yes descriptions from above, or additional medical history: _____

_____

Past Surgical History

Surgery or Procedure	Date of Procedure	Name of Surgeon/Provider

Family History

Indicate if your family members have any of these diseases (PGF= paternal grandfather; PGM= paternal grandmother; MGF= maternal grandfather; MGM= maternal grandmother)

Disease	Father	Mother	Brother	Sister	Son	Daughter	PGF	PGM	MGF	MGM
Asthma										
Collagen Vascular Autoimmune Disease Type:										
Chronic Obstructive Pulmonary Disease (COPD)										
Emphysema										
ILD/ Pulmonary fibrosis										
Lung Cancer										
Cancer, other										
Sarcoidosis										
TB										
Pulmonary Embolism/Thromobophilia										
Cystic fibrosis										
Diabetes Mellitus										
Coronary artery disease/heart attack										
Stroke										
Tuberculosis										
High cholesterol										
High blood pressure										
Frequent Pneumonia										
Rheumatoid arthritis										
Other										
Other										

Social History

1. Smoking History: ☐ I have **never** smoked
   I currently smoke: ☐ Cigarettes packs/day: _____ ☐ Cigar ☐ Pipe ☐ Hookah ☐ eCigarettes
   I previously smoked: ☐ Cigarettes ☐ Cigar ☐ Pipe Age Started: _____ Age Stopped: _____
   Average packs/day: _____ Are there smokers in your home? ☐ Yes ☐ No

2. Alcohol Use: Any problems with alcohol now or in the past? ☐ Yes ☐ No
   Current number of drinks per week: _____ Type(s) of alcohol: _____

3. Drug Use: Marijuana: ☐ Yes ☐ No; Street/Illicit Drugs: ☐ Yes ☐ No If yes, which? _____

4. Education:
   ☐ Some High School ☐ Completed High School/GED ☐ Some College
   ☐ Completed College ☐ Advanced Degree

5. Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed

6. Other diseases that run in the family:_____

7. Occupational History

Job Title	Dates of Employment	Description	Health risks/exposures	Injuries/Illnesses

Environmental History

1. Age of your home:_____ Location:_____ Years/months at residence:_____

2. Do you have exposure to:
   ☐ Mold ☐ Water Damage ☐ Leaking Roof ☐ Dirty Humidifier ☐ Swamp Cooler
   Other exposure concerns: _____

3. What animals (domestic and wild) do you have in or around your home? _____

4. In what country were you born? _____

5. Have you traveled in the last year? ☐ Yes ☐ No
   Outside of the U.S. to_____ Within the U.S. to_____

6. Did you have exposure to the World Trade Center site September, 2011? _____

Health Maintenance:

1. **Exercise**: Do you exercise regularly? ☐ Yes ☐ No Minutes/week: _____

2. **Vaccination/Immunization History**

Vaccine/Immunization		Date of last vaccination/immunization
Flu (Influenza)	☐ Yes ☐ No	
Pneumonia	☐ Yes ☐ No	
Tetanus	☐ Yes ☐ No	
BCG	☐ Yes ☐ No	
Chicken Pox (Varicella) If no, have you had chicken pox?	☐ Yes ☐ No ☐ Yes ☐ No	
Shingles	☐ Yes ☐ No	
HPV (Gardasil)	☐ Yes ☐ No	
tDAP (Pertussis, **list others**)?	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	—

3. **Health Screening History**

Vaccine/Immunization		Date of last test, Result
HIV Test	☐ Yes ☐ No	
Mammography	☐ Yes ☐ No	
Hepatitis C	☐ Yes ☐ No	
Colonoscopy	☐ Yes ☐ No	
Lung Cancer Screening Chest CT	☐ Yes ☐ No	
Coronary Artery CT	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

Please complete the symptom questionnaires on these pages if your visit concerns the following:

Asthma **page 7**
COPD **page 8**
ILD/Pulmonary Fibrosis **page 9**
Sleep Disorders **page 10**

Asthma Symptoms:

Asthma Control Test

For each question, please answer with 1-5, using the descriptions below the question:

In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school, or at home?	◯1 ◯2 ◯3 ◯4 ◯5
1. All of the time; 2. Most of the time; 3. Some of the time; 4. A little of the time: 5. None of the time	
During the past **4 weeks**, how often have you had shortness of breath?	◯1 ◯2 ◯3 ◯4 ◯5
1. More than once a day; 2. Once a day; 3. 3-6 times a week; 4. Once or twice a week: 5. Not at all	
During the past **4 weeks**, how often did you have **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	◯1 ◯2 ◯3 ◯4 ◯5
1. 4 or more nights a week; 2. 2 or 3 nights a week; 3. Once a week; 4. Once or twice: 5. Not at all	
During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	◯1 ◯2 ◯3 ◯4 ◯5
1. 3 or more times a day; 2. 1 or 2 times a day; 3. 2 or 3 times a week; 4. Once a week or less: 5. Not at all	
How would you rate your asthma control during the past **4 weeks**?	◯1 ◯2 ◯3 ◯4 ◯5
1. Not controlled at all; 2. Poorly controlled; 3. Somewhat controlled; 4. Well controlled; 5. Completely controlled	

COPD Symptoms:

COPD Assessment Test

For each item below, select the box that best describes you currently. Select only one answer for each question.

	0	1	2	3	4	5	
I never cough.	○	○	○	○	○	○	I cough all the time.
I have no phlegm (muscus) in my chest at all.	○	○	○	○	○	○	My chest is completely full of phlegm (mucus).
My chest does not feel tight at all.	○	○	○	○	○	○	My chest feels very tight.
When I walk up a hill or one flight of stairs I am not breathless.	○	○	○	○	○	○	When I walk up a hill or one flight of stairs I am very breathless.
I am not limited doing any activities at home.	○	○	○	○	○	○	I am very limited doing activities at home.
I am confident leaving my home despite my lung condition.	○	○	○	○	○	○	I am not at all confident leaving my home because of my lung condition.
I sleep soundly.	○	○	○	○	○	○	I don't sleep soundly because of my lung condition.
I have lots of energy.	○	○	○	○	○	○	I have no energy at all.

MMRC Dyspnea Score

Please Check the one best response to describe your shortness of breath

Grade

☐ 0 "I only get breathless with strenuous exercise"

☐ 1 " I only get short of breath when hurrying on the level or walking up a slight hill"

☐ 2 "I walk slower than people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level"

☐ 3 "I stop for breath after walking about 100 yards or after a few minutes on the level"

☐ 4 "I am too breathless to leave the house" or "I am breathless when dressing"

ILD/Pulmonary Fibrosis Symptoms

MMRC Dyspnea Score

Please Check the one best response to describe your shortness of breath

Grade

- ☐ 0 "I only get breathless with strenuous exercise"
- ☐ 1 " I only get short of breath when hurrying on the level or walking up a slight hill"
- ☐ 2 "I walk slower than people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level"
- ☐ 3 "I stop for breath after walking about 100 yards or after a few minutes on the level"
- ☐ 4 "I am too breathless to leave the house" or "I am breathless when dressing"

Sleep Disorders Symptoms:

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Situation	Chance of Dozing
Sitting and reading	☐0 ☐1 ☐2 ☐3
Watching TV	☐0 ☐1 ☐2 ☐3
Sitting inactive in a public place (e.g., a theater or a meeting)	☐0 ☐1 ☐2 ☐3
As a passenger in a car for an hour without a break	☐0 ☐1 ☐2 ☐3
Lying down to rest in the afternoon when circumstances permit	☐0 ☐1 ☐2 ☐3
Sitting and talking to someone	☐0 ☐1 ☐2 ☐3
Sitting quietly after a lunch without alcohol	☐0 ☐1 ☐2 ☐3
In a car, while stopped for a few minutes in traffic	☐0 ☐1 ☐2 ☐3

Review of Symptoms What symptoms have you experienced in the last **6 months**?

Constitutional
- Weight loss or gain ☐ Yes ☐ No
- Appetite changes ☐ Yes ☐ No
- Fatigue (impairs daily function) ☐ Yes ☐ No
- Fever ☐ Yes ☐ No
- Shakes/Sweats ☐ Yes ☐ No

Eyes
- Eye pain or drainage ☐ Yes ☐ No
- Visual changes ☐ Yes ☐ No
- Dry, irritated eyes ☐ Yes ☐ No

ENT/Mouth
- Ear pain or drainage ☐ Yes ☐ No
- Frequent sinus infections ☐ Yes ☐ No
- Hearing changes or loss ☐ Yes ☐ No
- Nosebleeds ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No

Respiratory
- Blood in your sputum ☐ Yes ☐ No
- Chest tightness ☐ Yes ☐ No
- Cough lasting >1 month ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Chest pain with inhalation or coughing ☐ Yes ☐ No

Cardiovascular
- Chest pain or heaviness ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Fainting or near fainting spells ☐ Yes ☐ No
- Swelling of feet or legs ☐ Yes ☐ No
- Shortness of breath lying flat in bed ☐ Yes ☐ No

Gastrointestinal
- Abdominal pain ☐ Yes ☐ No
- Blood in your stool ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Diarrhea or food intolerance ☐ Yes ☐ No
- Heartburn or indigestion ☐ Yes ☐ No
- Vomiting or nausea lasting >1 day ☐ Yes ☐ No
- Swallowing difficulty ☐ Yes ☐ No

Psychological
- Anxiety without clear explanation ☐ Yes ☐ No
- Sadness lasting days or weeks ☐ Yes ☐ No
- Hearing voices ☐ Yes ☐ No
- Thoughts of hurting yourself ☐ Yes ☐ No
- Thoughts of hurting others ☐ Yes ☐ No

Genitourinary
- Blood in your urine ☐ Yes ☐ No
- Menstrual changes ☐ Yes ☐ No
- Urinating that is painful or difficult ☐ Yes ☐ No
- Erection problems ☐ Yes ☐ No
- Vaginal discharge or bleeding ☐ Yes ☐ No

Musculoskeletal
- Broken bones ☐ Yes ☐ No
- Joint pain or swelling ☐ Yes ☐ No
- Muscle aches ☐ Yes ☐ No
- Muscle weakness ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No

Skin/Breasts
- Masses or lumps ☐ Yes ☐ No
- Nipple discharge ☐ Yes ☐ No
- Rashes or non-healing ulcers ☐ Yes ☐ No

Neurologic
- Seizures ☐ Yes ☐ No
- Coughing or choking with swallowing ☐ Yes ☐ No
- Excessive daytime sleepiness ☐ Yes ☐ No
- Extremity pain or burning sensation ☐ Yes ☐ No
- Hallucinations ☐ Yes ☐ No
- Numbness or tingling ☐ Yes ☐ No
- Difficulty falling/staying asleep ☐ Yes ☐ No

Endocrinologic
- Hair loss ☐ Yes ☐ No
- Frequent urination ☐ Yes ☐ No
- Increased thirst ☐ Yes ☐ No
- Heat or cold intolerance ☐ Yes ☐ No

Hematological/Lymphatic
- Bleeding from gums or nose ☐ Yes ☐ No
- Unexplained bruising ☐ Yes ☐ No
- Night sweats ☐ Yes ☐ No
- Swollen/Painful lymph nodes ☐ Yes ☐ No

Allergic/Immunologic
- Watery eyes ☐ Yes ☐ No
- Runny nose ☐ Yes ☐ No
- Food intolerance ☐ Yes ☐ No
- Frequent skin sores ☐ Yes ☐ No

Thank you for completing our questionnaire. Please be advised that completing preliminary health questionnaires does not establish a physician-patient relationship with Mount Sinai - National Jewish Health Respiratory Institute. This relationship begins at the time of your initial visit to our clinics, after we review your health history and conduct an initial evaluation.