Annapolis Asthma, Pulmonary & Sleep Specialists

Patient History Questionnaire

Name: _____ **Date of Birth:**_____

Medical History (please check all that apply):

☐Asthma ☐Hay fever ☐COPD ☐Pneumonia ☐Sinusitis ☐Sarcoidosis ☐GERD
☐High blood pressure ☐Heart disease ☐Congestive heart failure ☐Stroke ☐Diabetes
☐Peripheral vascular disease ☐Kidney disease ☐Liver disease ☐Cancer ☐Sleep apnea

Surgical History (please list most recent first):

Surgery: _____ Date: _____
Surgery: _____ Date: _____

Hospitalizations (please list most recent first):

_____
_____
_____

Allergies (please check all that apply):

☐Penicillin ☐Sulfa ☐Aspirin ☐Codeine ☐X-Ray contrast dye ☐Shellfish
☐No known drug allergies ☐Other: _____

Occupational and Environmental History:

Occupations: _____
Exposures (please check all that apply):
☐Asbestos ☐Chickens ☐Birds ☐Dogs ☐Cats ☐Farm animals
☐Any specific dusts, fumes, gases, or chemicals: _____

Social History:

Marital Status: ☐Married ☐Widowed ☐Divorced ☐Single ☐Other
Children: 0 1 2 3 ☐Other:_____
Tobacco: ☐Never smoked ☐Current smoker (_____packs/day for _____years)
☐Smokeless tobacco ☐Quit on _____ (_____packs/day for _____years)
Alcohol: ☐None ☐Occasional ☐2-3 times/week ☐Daily
Exercise: ☐None ☐Occasional ☐2-3 times/week ☐Daily

Family History:

Father: ☐Alive ☐Deceased Major Illnesses: _____
Mother: ☐Alive ☐Deceased Major Illnesses: _____
Bro/Sis: ☐Alive ☐Deceased Major Illnesses: _____
Bro/Sis: ☐Alive ☐Deceased Major Illnesses: _____
Bro/Sis: ☐Alive ☐Deceased Major Illnesses: _____

Name: _____ **Date of Birth:**_____

System Review (please check all that apply):

Constitutional: □Fever □Chills □Night sweats □Weight gain (___lbs) □Weight loss (____lbs)

Allergic: □Hay fever □Hives □Eczema

Cardiovascular: □Chest pain/pressure/tightness □Palpitations □Swelling in ankles
□Sudden awakening with shortness of breath

Endocrine: □Excessive hunger or urination □Heat or cold intolerance

Eyes: □Visual changes □Redness □Itching

ENT: □Headache □Postnasal drip □Hoarseness □Nasal discharge

Gastrointestinal: □Heartburn □Nausea/vomiting □Abdominal pain
□Change in bowel habits □Difficulty swallowing

GU: □Urinary frequency/pain/burning/blood

Heme/Lymph: □Easy bruising/bleeding □Swollen lymph glands

Musculoskeletal: □Joint pain/swelling/redness

Neurologic: □Fainting □Blackouts □Seizures

Psychiatric: □Depression □Anxiety □Panic attacks

Pulmonary: *(Please circle all that apply)*
Cough: none / occasional / most days ; for _____ days/wks/mos/yrs
Sputum Production: none / rarely / most days ; for _____ days/wks/mos/yrs
clear / white / yellow / green / blood
Wheezing: none / occasional / most days ; for _____ days/wks/mos/yrs
with exercise / with exposure to cold air
Shortness of Breath: at rest / with household chores
going up one flight of stairs / walking less than 1 block
Chest Pain: none / with deep breath / with coughing / with_____
*Pulmonary symptoms are made worse by: _____
_____

Skin: □Chronic rash □Change in color or texture of skin

Sleep: □Insomnia □Loud snoring □Excessive daytime sleepiness

Medications (please list all current medications and any supplemental or herbals you are taking):

Medication Name	Strength	Quantity	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL RECORDS AUTHORIZATION

Please review this document carefully as it describes how your medical information will be accessed and disclosed to individuals. Please check the applicable boxes and sign and date at the bottom of the page. Thank you.

Patient Name: _____ Date of Birth: _____

DISCLOSURE TO FAMILY AND FRIENDS

☐ I authorize Annapolis, Asthma, Pulmonary & Sleep Specialists to disclose and discuss information related to my care and treatment to the following individuals:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

☐ I am a resident at the following facility (nursing home, assisted living facility, rehabilitation center, etc.) and I authorize Annapolis, Asthma, Pulmonary & Sleep Specialists to disclose and discuss information related to my care and treatment to any and all representatives associated with their company.

Facility: _____

☐ I do NOT want Annapolis Asthma, Pulmonary & Sleep Specialists to disclose information related to my care and treatment to any family or friends without my written consent or legal authorization.
(Please note that checking this box indicates that we will not speak with any individuals, including immediate family members.)

_____ _____

Patient Signature **Date**