Northern Arizona Healthcare
EntireCare Rehab & Sports Medicine
Flagstaff Medical Center • Verde Valley Medical Center

Patient History Questionnaire – Outpatient Pulmonary Rehab

Patient Label Here

Name:_____ **Date:** _____

Phone:_____ **Date of Birth** _____ **Age**: ___

Email: _____

Primary Care Physician:_____

Pulmonary Physician: _____

Birthplace:_____ **City or Town of Residence**:_____

Have you traveled abroad (during the past two years)? ___Yes ___No. If yes, when and where?:_____

Marital status: ___Single ___Married ___Divorced ___Widowed ___Separated

What is your **living situation**? ___House ___Apartment ___Mobile Home ___Condo ___Hogan

Does your home have: ___Single level ___Multi-level __Split level

Does your entrance have: ___Ramp ___Stairs – How many? ____with railing ___Right ___Left ___None

Do you use the stairs? ___Yes ___No. Do you have difficulty going up/ down stairs? ___Yes ___No

Do you have forced-air heating? ___Yes ___No Do you have an air purifier/ cleaner? ___Yes ___No

Pulmonary Health History:

How often do you see your PCP? _____ Your pulmonary physician? _____

Do you cough? ☐ Yes ☐ No When? ☐ AM ☐ PM ☐ Nighttime ☐ All day

Have you coughed up blood? ☐ Yes ☐ No If yes, when?_____

Do you have any of the following? ☐ chest pain ☐ dizziness/ unsteadiness ☐ feel swollen ☐ fatigue

☐ hoarseness ☐ ankle swelling ☐ wheezing What triggers wheezing?_____

Pulmonary Infections:

How many per year?____ Antibiotics you take _____

I know I have an infection when: _____

Pulmonary Hospitalizations:

How many in past year? ____ How many previously? _____ Which hospital? _____

Emergency Department visits for pulmonary reasons: In past year _____ In previous year _____

Have you ever been on a respirator (ventilator)? ☐ Yes ☐ No If yes, when? _____

Shortness of Breath: My breathing is most difficult: ☐ a.m. ☐ p.m. ☐ bedtime

When I get short of breath I (check all that apply): ☐ stop and rest ☐ pursed-lip breathe ☐ deep breathe

☐ use inhalers ☐ use aerosol machine ☐ open windows ☐ use a fan ☐ practice relaxation

Usual household duties I perform: ___Cooking ___Cleaning ___Yardwork ___Laundry

___Grocery shopping ___Driving ___Finances

Do you have difficulty performing the above? ___Yes ___No If yes, which ones?_____

_____

My major sources for emotional support:

_____/_____/_____

Will transportation to this program be a problem for you? ___Yes ___No

Occupational History:

Current or former occupation: _____Year of Retirement/ Disability:_____

Occupational Exposure ___ Welding ___ Asbestos___ Dust ___ Mining ___ Quarry ___ Foundry

___ Gas/fumes ___ Chemicals ___ Sandblasting ___ Livestock/poultry

Allergy History: Do you have allergies? ___Yes ___No

I am allergic to the following:

Foods: _____

Medications: _____

Environmental: ___Dust ___Mold ___Pollens ___Grass ___Other _____

I have difficulty breathing when exposed to the following environmental irritants:

___ Dust ___ Smog ___ Humidity ___ Perfume/ Fragrances ___Tobacco smoke ___ Winds

___ Rapid changes in temperature ___ Solvents ___ Household cleaners

___ Other _____

Vaccine History:

Do you receive the flu vaccine annually? ___ Yes ___ No If no, explain_____

Did you receive the pneumonia vaccine? ___ Yes ___ No If no, explain _____

Smoking history:

Have you ever smoked? ___Yes ___ No If yes, how many packs/ day___? Year started _____

Do you still smoke? ___ Yes ___ No If no, when did you quit _____

Current exposure to second-hand smoke: ___ None ___ At home ___ At work ___ Social situations

Medical history:

___ chronic bronchitis	___ emphysema	___ bronchiectasis	___asthma
___ tuberculosis	___pulmonary fibrosis	___ asbestosis	___ diabetes
___ high blood pressure	___ arthritis	___ osteoporosis	___ pneumonia
___ collapsed lung	___ lung surgery	___ sinus problems	___ seizures
___ "passing out"	___ cancer (what kind?) _____		___ heart disease
___ heart surgery	___ heart stents	___ heart palpitations	___ depression
___ anxiety	___ orthopedic problems _____		___ cystic fibrosis
___ sarcoidosis	___ surgeries: _____		

Activity and exercise history:

Do you currently do purposeful walking? ☐ No ☐ Yes How many days/ week? ____ How many miles? ____
How many minutes each day? _____

Do you do any purposeful exercise at all (ride a bike, swim, etc.)? ☐ No ☐ Yes How many days/ week? ____

Sleeping history: Usual bedtime _____ Usual wake-up time _____

Do you take naps during the day? ☐ Yes How many? _____ How long? _____ ☐ No

How many pillows do you use when you sleep? _____

Do you feel rested when you wake up? ☐ Yes ☐ No ☐ Somewhat

Do you snore? ☐ Yes ☐ No ☐ Don't know

Respiratory Home Care Equipment:

EQUIPMENT	FREQUENCY	EQUIPMENT	FREQUENCY	EQUIPMENT	FREQUENCY
☐ Peak Flow Meter	_____	☐ Aerosol Machine	_____	☐ Suction Machine	_____
☐ CPAP Machine	_____	☐ Mechanical Percussor	_____	☐ Acapella	_____
☐ Pep Valve	_____	☐ IPV unit	_____	☐ Ventilator	_____

Oxygen therapy:

I have used it since _____ Flow rate prescribed: _____ Flow rate used: _____

Oxygen System: ☐ concentrator ☐ intermittent flow ☐ liquid ☐ tank

Oxygen used: ☐ continuously ☐ with sleep ☐ with exercise ☐ only when I need it

I change my oxygen tubing every: ☐ week ☐ 2 weeks ☐ 3-4 weeks ☐ 1-2 months ☐ I don't remember

Medications:

Do you use a spacer with your inhalers? ☐ Yes ☐ No

How do you pay for your prescriptions? ☐ out of pocket ☐ co-pay ☐ insurance covers all

Inhaler	Dose	How often prescribed	How often used	Reason for inhaler

Other prescribed medications	Dose	How often do you take it	Reason you take it

Over the counter medications	Dose	How often do you take it	Reason you take it

Day-to-day Living:

My usual temperament (mood) is: _____

In my leisure time, I like to: _____

I usually deal with stress by: _____

In terms of my health, I am most afraid that:

I think my spouse/ partner is most afraid that:

I have a: ☐ Living Will ☐ Durable Power of Attorney for Health Care ☐ Natural Death Act ☐ Five Wishes