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HEAL HIS

Patient Name: _____

Date: _____

Please complete this questionnaire and bring it with you to your appointment.

Why were you referred to Avera Medical Group Pulmonary & Sleep Medicine?

Referring Doctor:

Name: _____

Address: _____

Phone: _____

Primary Care Doctor:

Name: _____

Address: _____

Phone: _____

Are you:

Married Divorced Widowed Single

Do you have children? Yes No

How many: _____ Girls _____ Boys

Grandchildren? _____

Anybody in your family had:

Emphysema _____

Asthma _____

Sarcoidosis _____

Cystic Fibrosis _____

Cancer _____

Heart Disease _____

Diabetes _____

Arthritis _____

Others _____

Do you travel outside the Midwest? Yes No

Places where you spend more than 1 month/year: _____

What is your profession(s) (if retired list prior)

Do you have pets? Yes No

What kind? _____

Were you ever exposed to:

Asbestos Smoke/fumes

Radon Radiation

Silo (Filling) Moldy Hay

Others _____

Are you allergic to any medication? Yes No

List Allergies:

Do you currently smoke? Yes No

If not, have you ever? Yes No

When did you quit? _____

If yes, how many packs/day? _____

What is the highest # of packs/day? _____

How old were you when you started? _____

Other smokers in the household? Yes No

Who? _____

Do you regularly consume alcohol? Yes No

How much? _____

Have you been an alcoholic? Yes No

Do you drink coffee or tea? Yes No

How much? _____

Sodas (caffeinated beverages)? Yes No

How much? _____

Ever abused/used illicit drugs? Yes No

How much? _____

What is your medical history (with dates):

Hypertension Asthma Pneumonia

Heart Disease Diabetes Emphysema

Sleep Disorder Depression Sinusitis

Blood Clots in the Lungs/Legs

Prior Surgeries (with dates):



Patient Name: _____

Date: _____

Do you suffer any of the following? (check what is relevant)

General Health Problems:

- Fever
- Sweating at night
- Loss of appetite
- Weight changes, how much? _____
Over what period of time? _____
- Others _____
- Chills
- Malaise
- Lack of energy

Respiratory Problems:

- Dry cough
- Cough up blood
- Runny nose
- Sinus pain
- Postnasal drip
- Chest tightness
- Difficulty swallowing/choking
- Shortness of breath when resting
- Shortness of breath when climbing stairs
- Shortness of breath when lying flat on bed
- Others _____
- Phlegm
- Wheezing
- Sneezing
- Ear infections
- Sore throat
- Chest pains

Cardiac Problems:

- Chest pain when walking/exercising
- Chest pain when resting
- Heart skipping a beat
- Heart racing
- Cramps/pains in the legs when walking
- Cramps/pains in the legs when lying flat
- Others _____
- Feet/legs swelling
- Heart murmur
- Passing out

Neurological Problems:

- Tremor/shaking
- Headaches
- Light-headed
- Weakness of any part of your body
Which _____
- Numbness of any part of your body
Which _____
- Others _____
- Seizure
- Migraines
- Dizziness

Psychological Problems:

- Depression
- Mania
- Phobia
- Others _____
- Easy crying
- Anxiety
- Claustrophobia

Digestive Problems:

- Indigestion
- Acid/pain in the stomach
- Nausea
- Diarrhea
- Vomiting blood
- Jaundice
- Others _____
- Stomach cramps
- Heartburn
- Vomiting
- Constipation
- Passing blood
- Dark tarry stools

Urinary Problems:

- Blood in urine
- Burning in urine
- Frequent Urination/Urgency
- Difficulty passing the urine/
low flow
- Others _____
- Stone in urine
- Urinating at night
- Scrotal swelling

Joints Problems:

- Back pain
- Gout
- Joint pains; which _____
- Swelling of joints, which _____
- Fractures _____
- Others _____
- Neck pain
- Morning stiffness

Skin Problems:

- Rash
- Easy bruising
- Discoloration
- Feet ulcers/wounds
- Moles changing in size or color
Where _____
- Others _____
- Eczema
- Hives
- Skin scaling
- Skin ulcers

Hematological Problems:

- Swelling of lymph glands, where _____
- Anemia
- Others _____
- Easy bleeding

Genital Problems (women only):

- Date of last period _____
- Are pregnant? _____
- Irregular menses
- Painful menses
- Vaginal discharge
- Others _____
- Copious menses
- Hot flashes
- Genital ulcers

Endocrine/Glands Problems:

- Can't tolerate cold
- High sugar/diabetes
- Thyroid problems _____
- Others _____
- Can't tolerate heat
- Cholesterol/lipids

