National Jewish Health®

Breathing Science is Life.®

▲ Please use blue or black ink

Patient Name: ________________________

Date of Birth: _________________________

(Patient Label)

ADULT PATIENT QUESTIONNAIRE

Please fax to 303-398-1211 or bring to your first appointment

Today's Date:_____/_____/_____

Your Cell Phone: (_____)______________

Emergency Contact Name:____________________

Emergency Contact Phone: (_____)__________

Physician and Pharmacy Information

Primary Care Physician (Family Practice, Internist)

Name ________________________

Address ________________________

____

____

Phone ________________________

Fax ________________________

Email ________________________

Referring Physicians

Name ________________________

Address ________________________

____

____

Phone ________________________

Fax ________________________

Email ________________________

Other Physician/ Provider with Whom You Would Like Us to Communicate:

Name ________________________

Address ________________________

____

Phone ________________________

Fax ________________________

Email ________________________

Other Physician/ Provider with Whom You Would Like Us to Communicate:

Name ________________________

Address ________________________

____

Phone ________________________

Fax ________________________

Email ________________________

Preferred Retail Pharmacy

Name ________________________

Address ________________________

____

Phone ________________________

Fax ________________________

Mail Order/Alternate Pharmacy

Name ________________________

Address ________________________

____

Phone ________________________

Fax ________________________

What would you like to talk about during your visit?

___

___

___

Medical History:

Past Medical History: Have you ever had any of the following?

Condition			Condition		
Allergies	☐ Yes	☐ No	Irregular Heart Rhythm	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No	Kidney Failure or Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bone Fracture as an Adult	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Bronchiectasis	☐ Yes	☐ No	Mycobacterial Infection	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Obstructive Sleep Apnea	☐ Yes	☐ No
Cancer: ____________	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
COPD	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No	Pulmonary Artery Hypertension	☐ Yes	☐ No
COVID	☐ Yes	☐ No	Pulmonary Embolism	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Pulmonary Fibrosis(**if yes, describe below**)	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Recurrent Infections	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
DVT	☐ Yes	☐ No	Sarcoidosis	☐ Yes	☐ No
Esophageal Disease	☐ Yes	☐ No	Scleroderma	☐ Yes	☐ No
GERD/Reflux	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Heart or Valve Defect	☐ Yes	☐ No	Sjogren's Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Skin Disorders (e.g., ☐Psoriasis,☐ Acne)	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Shortness of Breath(**if yes, describe below**)	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No	Tuberculosis (**if yes, describe below**)	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No	Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No

Please list all other medical conditions past and present:

___

___

___

Past Surgical History

Surgery or Procedure	Date of Procedure	Name of Surgeon/Provider

Vaccination/Immunization History

Vaccine/Immunization	Date of Last Immunization Month / Year
High Dose Flu Shot (Fluzone)	/
Flu Shot (Influenza)	/
Pneumovax (Pneumococcal Pneumonia-PPSV)	/
Prevnar (Pneumococcal Pneumonia-PneumoPCV)	/
Shingrix (Shingles or Herpes Zoster)	/
Tdap (Tetanus-Diptheria-Pertussis)	/
Zostavax (Shingles or Herpes Zoster)	/
1st Covid-19 □ Janssen □ Moderna □ Pfizer	/
2nd Covid-19 □ Janssen □ Moderna □ Pfizer	/
3rd Covid-19 Booster □ Janssen □ Moderna □ Pfizer	/
4th Covid-19 Booster □ Janssen □ Moderna □ Pfizer	/

Medications Taken Regularly

Include all oral, inhaled, intravenous, and subcutaneous medications as well as 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				

Allergies

Allergic to: ☐IV Contrast Dye: Type_______________

Please list medication or severe food allergies	Describe reaction

Oxygen and Respiratory Equipment

1. Do you use oxygen? ☐ Yes ☐ No

   Amount: at rest__________ sleeping__________ with activity__________

   ☐ Nasal Cannula ☐ Mask ☐ Transtracheal

2. Do you use a☐ CPAP or ☐Bi-PAP Settings:_____________________

3. What company delivers your oxygen or other medical equipment? ______________________________

Family History

Indicate if your family members have any of these diseases (GM=Grandmother, GF=Grandfather, Maternal=Mothers's side Paternal=Father's side, Sis=Sister, Bro=Brother and Dau=Daughter).

Disease	Maternal			Paternal			Siblings			Children			
	Mom	GM	GF	Dad	GM	GF	Sis	Bro		Dau	Son		
Asthma													
Autoimmune Disease Type:													
Cancer Type **(specify in box):**													
□ COPD / □ Emphysema													
Coronary Artery Disease (CAD)													
Diabetes Mellitus													
Frequent Pneumonia													
Heart Attack													
High Blood Pressure													
High Cholesterol													
□ Interstitial Lung Disease / □ Pulmonary Fibrosis													
Pulmonary Embolism (PE)													
Rheumatoid Arthritis (RA)													
Stroke													
□ Osteoporosis/ □ Fragile Bones and/or □ Hip Fracture													
Other #1													
Other #2													
Other #3													

Other diseases that run in the family: ____

____

____

____

____

Social History

1. Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed
2. Smoking History: ☐ I have **never** smoked

   I currently smoke: ☐ Cigarettes packs/day (**circle one**): ________ ☐ Cigar ☐ Pipe ☐ eCigarettes
   ☐ Other: ________________________________

   If you currently smoke, are you interested in quitting? ☐ Yes ☐ No

   I previously smoked: ☐ Cigarettes ☐ Cigar ☐ Other Age Started: _________ Age Stopped: ________

   Average packs/day (**circle one**): ______ Are there smokers in home? ☐ Yes ☐ No

   Smokeless tobacco: ☐ Yes ☐ No Number of years: _________
3. Marijuana: ☐ Yes ☐ No Route: ☐ Inhaled ☐ Edible Medical: ☐ Yes ☐ No
4. Street/Illicit Drugs: ☐ Yes ☐ No If yes, which? ________________
5. Alcohol Use: Any problems with alcohol now or in the past? ☐ Yes ☐ No

   Current number of drinks per week: ________ Type(s) of alcohol: ________________________________
6. Exercise: Do you exercise regularly? ☐ Yes ☐ No

   Please Describe: ____
7. Fall Risk: Have you fallen in the past 3 months? ☐ Yes ☐ No

   Do you feel unsteady when standing? ☐ Yes ☐ No

   Do you use a cane, walker or wheelchair? ☐ Yes ☐ No

   Do you have a fear of falling? ☐ Yes ☐ No

Occupational History- Please start with the most recent job and work backwards

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

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

General

Weight change	☐ Yes ☐ No
Fatigue (impairs daily function)	☐ Yes ☐ No
Fever/Chills	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No
Decreased Appetite	☐ Yes ☐ No

Eyes

Visual changes	☐ Yes ☐ No
Dry, irritated or painful eyes	☐ Yes ☐ No

ENT/Mouth

Ear pain or drainage	☐ Yes ☐ No
Frequent sinus infections/ sinus pain	☐ Yes ☐ No
Hearing changes or loss	☐ Yes ☐ No
Nosebleeds	☐ Yes ☐ No
Post Nasal Drip	☐ Yes ☐ No
Change in voice/ hoarseness	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No
Ulcers/Sores in the eyes, mouth or nose	☐ Yes ☐ No

Respiratory

Sputum Production	☐ Yes ☐ No
Chest tightness	☐ Yes ☐ No
Cough lasting >1 month	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No
Coughing up blood	☐ 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	☐ Yes ☐ No
Heartburn or indigestion	☐ Yes ☐ No
Vomiting or nausea lasting >1 day	☐ Yes ☐ No
Swallowing difficulty	☐ Yes ☐ No

Allergic/Immunologic

Watery or itchy eyes	☐ Yes ☐ No
Runny nose	☐ Yes ☐ No
Food intolerance	Yes No

Psychological

Anxiety without clear explanation	☐ Yes ☐ No
Sadness lasting days or weeks	☐ Yes ☐ No
Depression	☐ Yes ☐ No

Genitourinary

Blood in your urine	☐ Yes ☐ No
Urinating that is painful or difficult	☐ Yes ☐ No
Erection problems	☐ Yes ☐ No

Musculoskeletal

Joint pain or swelling	☐ Yes ☐ No
Muscle aches or tenderness	☐ Yes ☐ No
Muscle weakness	☐ Yes ☐ No
Stiffness in the joints	☐ Yes ☐ No
Ulcers on the fingertips	☐ Yes ☐ No

Skin

Hives	☐ Yes ☐ No
Rash	☐ Yes ☐ No
Non-healing ulcers	☐ Yes ☐ No
Skin cancer	☐ Yes ☐ No
Color change or coldness in fingertips	☐ Yes ☐ No
Other changes in skin	☐ Yes ☐ No

Neurologic

Seizures	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No
Extremity pain or burning sensation	☐ Yes ☐ No
Numbness or tingling	☐ Yes ☐ No

Endocrine

Frequent urination	☐ Yes ☐ No
Increased thirst	☐ Yes ☐ No
Heat or cold intolerance	☐ Yes ☐ No
Menstrual changes	☐ Yes ☐ No

Hematological/Lymphatic

Inappropriate bleeding	☐ Yes ☐ No
Unexplained bruising	☐ Yes ☐ No
Swollen/Painful lymph nodes	☐ Yes ☐ No

Sleep

Snoring	☐ Yes ☐ No
Do you stop breathing at night?	☐ Yes ☐ No
Excessive Daytime Sleepiness	Yes No
Falling asleep when you should not	Yes No
Difficulty falling or staying asleep	Yes No

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