Patient Name: _____ Date of Birth: _____

		Yes	No	Explanation
1)	Have you had any emergency room visits or hospitalizations in the last 12 months? If so, please tell us where, when, and what happened.	☐	☐	_____ _____ _____
2)	Have you taken any oral steroids or antibiotics in the last 12 months? If so, please tell us when, what you took, and why.	☐	☐	_____ _____ _____
3)	Have your other doctors identified any new diagnoses or medical problems since your last visit? If so, please describe.	☐	☐	_____ _____
4)	Did you have any medical procedures, surgeries, radiologic studies or outside test results since your last visit? If so, please let us know what you had and the results.	☐	☐	_____ _____ _____

Physician Only:

Number of exacerbations in the last 12 months:

☐

Asthma COPD ILD Bronchiectasis

Initials _____

5) How much oxygen do you use at rest_____ with sleep_____ with activity_____

6) Do you use CPAP (Y/N)?_____ If so, what are the pressure settings_____

7) What is your daily activity level or exercise regimen? _____
_____

8) What questions do you want the doctor to address today?
_____
_____
_____
_____

9) **Are you experiencing any of the following symptoms?** (please **circle** all that apply—all items **not** circled are negative)

Fever	Chest Pain	Numbness
Chills	Palpitations	Weakness or tingling in any part of body
Night Sweats	Swelling in feet or legs	Blood in the urine
Loss of appetite	Nausea	Pain with urination
Difficult speech or swallowing	Vomiting	Increased urinary frequency at night
Hoarseness	Abdominal pain	Rash
Congestion	Heartburn	Hives
Runny nose	Weight change	Other changes in the skin
Change in voice	Blood in stool	Bleeding
Cough	Joint pain	Blood clots
Sputum production	Joint swelling	Easy bruising
Shortness of breath at rest	Muscle pain	Anxiety
Shortness of breath with exercise	Muscle tenderness	Depression
Coughing up blood	Difficulty with balance	None of the above

Other _____

Patient Signature _____ Date/Time _____

Physician Signature _____Date/Time_____

National Jewish Health
Breathing Science is Life.

ÌON092eÎ (Patient Label)

Patient Question/Checklist _CC MRN: X_____Appt. CSN: _____

Pulmonary/ILD Follow Up Visit Questionnaire NSG 398E (4/17)

(OVER)