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. | ☐ | ☐ | ________________ |

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?

________________________________________________________________

***Physician Only:***

Number of exacerbations in the last 12 months:

☐

Asthma COPD ILD Bronchiectasis

Initials ____________

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______________

HIPAA Patient Request _CC

(Patient Label)

MRN: X___________Appt. CSN: ______________

**Pulmonary/ILD Follow Up Visit Questionnaire**

NSG 398E (4/17)