Baylor University Medical Center - Baylor Martha Foster Lung Care Center
4004 Worth St. Suite 300 Dallas, TX 75246 214 820 3500

PATIENT QUESTIONNAIRE

Please complete this patient self-history form to the best of your ability. The information you provide will help to determine your treatment plan.

Name: ________________________________ Date of Birth: __________________ Age: _______

When did you first notice your breathing problems? ____

What bothers you most about your breathing? ____

How often do you have breathing problems? ____

Is your breathing worse at certain times of the year?
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Is your breathing worse at certain times of the day? ____

Is your breathing worse at certain places? ____

Do you get nervous or excited when you have trouble breathing? ________________________________

Have you ever done breathing exercises to help when you become short of breath? __________________

What doctor is currently taking care of you breathing problems?
Dr. ______________________________________ Office telephone ______________________________

Have you recently had:

Sinus x-ray	Yes or No	When _____________________
Chest x-ray	Yes or No	When _____________________
Breathing test	Yes or No	When _____________________
Skin test	Yes or No	When _____________________
Allergy Shots	Yes or No	When _____________________
Influenza Vaccine	Yes or No	When _____________________
Pneumonia Vaccine	Yes or No	When _____________________

Have you experienced any of the following?

_____ Nasal congestion
_____ Runny nose
_____ Post-nasal drip
_____ Frequent sneezing
_____ frequent coughing
_____ nose bleeds
_____ productive cough - how much per day _________________________________
_____ itching of throat or roof of mouth
_____ sore throat
_____ pressure behind eyes, forehead
_____ earaches, ringing in the ears
_____ eyes itching, watery, red
_____ sinus infections

Legend:

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Are you currently using oxygen? Yes or No If yes, how much? ______________________________

If you are using oxygen, when do you normally wear it? ______________________________

FAMILY/SOCIAL HISTORY

Marital status: Single Married Divorced Widowed
If married, how long?__________

With Whom do you live: Name Relationship

____
____
____
____

Does anyone in your family have any of the following?

Yes or No Relationship

Emphysema ______________________________
Bronchitis ______________________________
Asthma ______________________________
Tuberculosis ______________________________
Lung Cancer ______________________________
Pneumonia ______________________________
Cystic Fibrosis ______________________________
Allergies ______________________________
Heart Disease ______________________________
High Blood Pressure ______________________________
Arthritis ______________________________
Diabetes ______________________________

Have you ever smoked? Yes or No

If yes, what? Cigarettes Cigars Pipe Other ______________________________

How often or how many per day? ____________________ How many years? ____________________

Have you quit? Yes or No If yes please indicate what year ______________________________

Are there any smokers in your home? Yes or No Previously? Yes or No

Is there smoking in your work environment? Yes or No

Do you use illegal drugs? Yes or No

Legend:

Please circle the following that would apply to your home environment.

Do you live in a:	House Apartment Trailer Other ________________
Is your home:	Slab Pier and beam
Is your air conditioning:	Window Central None
Do you have humidifiers:	Central Room None
Are your pillows:	Feather Foam Dacron Fill
Is your mattress:	Water Innerspring Foam How old? ______________
Is your flooring:	Carpeting Wood floor Vinyl Ceramic tile
Do you have houseplants?	Yes or No
Do you have pets:	Dogs ______ Cats ______ Other __________________
Do animals affect your breathing?	Yes or No

How many hours of sleep do you need to feel good? ______ How often do you awaken? ______________

How many pillows do you sleep on? ____

Do you often feel tired even after a "good night's rest"? ____

Do you wake up because of problems with your breathing? ____

Do you snore? Yes or No

Do you use CPAP or BIPAP at night? (If yes, circle)

EXERCISE HISTORY:

Do you exercise? Daily _____ times a week Sporadic None

Type of exercise: Walk Bike Jog Swim Dance Aerobics Water aerobics
Other ___________

Do you belong to: Health club Own your equipment Other ________________________________

Do you become short of breath during exercise? Yes or No

Do you have to stop exercising because of your shortness of breath? Yes or No

Do you have to use your inhaler before exercise? Yes or No During exercise? Yes or No

Are there any medical problems that would prevent you from exercising? Yes or No
Please explain: ____

Do you use a: Walker Cane Other ______________________________________

Legend:

Daily Activities:

Please check the activities that cause you to feel short of breath:

____ Showering
____ Hair grooming
____ Cleaning
____ Vacuuming
____ Dressing
____ Cooking
____ Doing laundry
____ Yard work
____ Other ______________________________

Please check the activities that you are able to do:

____ Grocery shop
____ Shop at the mall
____ Attend church
____ Attend family functions
____ Go out to eat
____ Attend social events
____ Attend community events
____ Travel

Please list some activities you are no longer able to perform but have the desire to perform. ____________
____

What significant events, positive or negative, have occurred for you in the past two years? ______________________________
____

Are there any significant events that have occurred that have affected your lifestyle? ______________________________
____

List what you consider to be your major stress factors in your life: ______________________________
____

Rate your stress level on a scale of 1 – 10 below

No stress 0 1 2 3 4 5 6 7 8 9 10 High stress

What coping techniques have you used or still use to deal with your stress? ______________________________
____

Do you have any cultural/religious/spiritual needs that we should be aware of?
____

Do you have a power of attorney for health related affairs? Yes or No

EMPLOYMENT HISTORY:

Present occupation: ______________________________

Previous employment if retired or unemployed: ______________________________

Legend:

List any previous jobs that include – industrial, mining, farming or any position requiring the use of chemicals.

____

Have any of your work environments or school environments caused you to be short of breath or sick?
Yes or No If yes, please describe ____

____

Last level of education completed:

______ > High school
______ High school diploma
______ College 1 2 3 4
______ Other ________________________________

Legend:

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