# PULMONOLOGY DEPARTMENT

1625 Medical Center Point, Ste. 260, Colorado Springs, CO 80907
(719) 227-7800

## INITIAL VISIT QUESTIONNAIRE

**Name** ______________________________ **Sex:** ☐ **Male** ☐ **Female**
**Date of birth** /_____/_____ **Age** _______ **Social Sec. #** ________ - _________ - __________
**Home phone** ________________________ **Work/Cell phone** __________________________
**Address** ______________________________________________________________________
**Marital status** ___________ **Occupation** _________________ **Height** __________**Weight** ______

Please state in your own words the reason why you were referred to this clinic:
___________________________________________________________________________________
How long have you had this problem?: _____________________________________________
Have you ever been treated for this problem before: ☐ Yes ☐ No
If yes where: ____________________________________________________________________
Have you had any previous tests regarding this problem: ☐ Yes ☐ No
If yes, what and where: __________________________________________________________
Have you had any chest X-rays for this problem, or for tuberculosis that were done somewhere other than DaVita Medical Group? ☐ Yes ☐ No **If yes, please get your chest X-rays and chest CT scans on disc and bring them with you to your appointment.**

| Do you have a history of: | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Fatigue/tiredness | | | Constipation | | |
| Loss of appetite | | | Pancreatitis | | |
| Excessive weight loss or gain | | | Gall stones | | |
| Problems with your vision | | | Liver disease | | |
| Problems with your hearing | | | Frequent urination | | |
| Headaches | | | Blood in your urine | | |
| Dizziness | | | Painful urination | | |
| Repeat sinus/throat infections | | | Getting up at night to urinate | | |
| Post-nasal drip | | | Vaginal discharge | | |
| Sinus pain/tenderness | | | Seizures | | |
| Nasal congestion | | | Stroke | | |
| Fevers | | | Loss of consciousness | | |
| Nosebleeds | | | Numbness | | |
| Shortness of breath | | | Tingling or burning of the skin | | |
| Coughing up blood | | | Anxiousness/Anxiety | | |
| Persistent cough | | | Depression | | |
| Tuberculosis | | | Stress | | |
| Fainting | | | Joint pain or joint swelling | | |
| Angina/Chest pain | | | Muscle pain | | |
| Heart attack | | | Osteoporosis/Bone loss | | |
| High blood pressure | | | Rashes | | |

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| Do you have a history of: | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Other Heart Problems | | | Thyroid problems | | |
| Blood clots<br>Heartburn | | | Diabetes<br>Bruising easily | | |
| Changes in your bowel habits | | | Bleeding | | |
| Nausea/Vomiting | | | Anemia | | |
| Abdominal Pain | | | Other blood problems | | |
| Blood in your stool | | | Swollen glands | | |
| Persistent Diarrhea | | | Seasonal Allergies | | |

**Sleep History**

| Do you have a history of: | YES | NO |
|---|---|---|
| Daytime sleepiness | | |
| Insomnia | | |
| Waking frequently during the night | | |
| Snoring | | |
| Sleep apnea | | |
| An urge to move your legs when at rest or before bedtime | | |
| If yes, does it help if you move your legs? | | |
| Falling asleep while driving | | |
| Is your sleep pattern different on weekends or vacations | | |

What time do you go to bed? __________

How long does it take you to fall asleep? _______

How many times do you wake up during the night?__________

What time do you wake up? __________________

How many **hours** do you sleep each night? ______________

**Social History**

Tobacco: ☐ Currently Smokes ☐ Never ☐ Quit

______ packs per day for _____ years

Alcohol: ☐ Yes How much ______________

☐ Never ☐ Quit

Recreational Drugs: (marijuana, cocaine, etc) *(This information is confidential!)*

☐ Yes ☐ Never ☐ Quit

Pets: ☐ Yes ☐ No

**Tuberculosis History**

**Have you ever had:**

Contact with anyone having TB ☐ Yes ☐ No

A skin test for TB ☐ Yes ☐ No

If "Yes" Where _________________

When __________ Result _________

Treatment for a positive TB test ☐ Yes ☐ No

Active Tuberculosis ☐ Yes ☐ No

If "Yes" to either of the last two questions, what drug was used and for how long ____________

**Please list any major illnesses or hospitalizations you have had (and if known, the year):**

| |
|---|
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| |
| |

**Please list any surgeries/operations you have had and the year:**

| |
|---|
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**Please list all medications you take, the strength, and how often you take it:**

| Medication name | Dose/strength (# of mg) | How often you take it (example – 1 tablet, twice a day) |
|---|---|---|
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**Please list any medications to which you are allergic:**

| |
|---|
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| |
| |

PULMONOLOGY DEPARTMENT

# PULMONARY MEDICINE-REVIEW OF SYSTEMS (FEMALE)

1625 Medical Center Point, Ste. 260, Colorado Springs, CO 80907

**Patient Name** ________________________________________ **Date**________________________

Please check any symptom below that you have. Ask your provider if you do not understand the question or want to give more specific details.

**Constitutional**

- ☐ Fever
- ☐ Chills
- ☐ Feeling poorly
- ☐ Feeling tired
- ☐ Recent weight gain _____lbs
- ☐ Recent weight loss _____lbs

**Eyes**

- ☐ Eye pain
- ☐ Red eyes
- ☐ Eyesight problems
- ☐ Discharge from eyes
- ☐ Dry eyes
- ☐ Eyes itch

**Ear, Nose, Throat**

- ☐ Earache
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Nasal discharge
- ☐ Sore Throat
- ☐ Hoarseness

**Cardiovascular**

- ☐ Chest pain
- ☐ Palpitations
- ☐ Fast heart rate
- ☐ Slow heart rate
- ☐ Leg cramps with exercise
- ☐ Swelling of lower leg(s)

**Respiratory**

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Short of breath at night
- ☐ Short of breath when laying flat
- ☐ Short of breath with activity

**Gastrointestinal**

- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Black/bloody bowel movements

**Genitourinary**

- ☐ Pain with urination
- ☐ Urine leaking
- ☐ Pelvic pain
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Abnormal vaginal bleeding

**Musculoskeletal**

- ☐ Achy joints
- ☐ Pain in joints
- ☐ Swelling in joints
- ☐ Stiff joints
- ☐ Pain in arms or legs
- ☐ Swelling of lower leg(s)

**Integumentary**

- ☐ Abnormal patch of skin
- ☐ Skin wound
- ☐ Itching
- ☐ Change in a mole
- ☐ Breast pain
- ☐ Breast lump

**Neurological**

- ☐ Confusion
- ☐ Seizures or convulsion
- ☐ Dizziness
- ☐ Fainting
- ☐ Weak or numb limb
- ☐ Difficulty walking

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**Psychiatric**

- ☐ Suicidal thoughts
- ☐ Anxiety
- ☐ Change in personality
- ☐ Disturbed sleep
- ☐ Depression
- ☐ Emotional problems

**Endocrine**

- ☐ Bulging eye(s)
- ☐ Feeling of weakness
- ☐ General muscle weakness
- ☐ Hot flashes
- ☐ Deepening of the voice

**Heme/Lymph**

- ☐ Easy bleeding
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ Swollen neck glands

**Other problems (please explain):**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Sleep History**

- ☐ Daytime sleepiness
- ☐ Insomnia
- ☐ Waking frequently at night
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Urge to move legs at rest or in bed
- ☐ Helps to move legs
- ☐ Change in sleep pattern

When is your bedtime? ______________________________________

How long does it take you to fall asleep? ____________________________

How many times do you awaken at night? ____________________________

What time do you wake up in the morning? ___________________________

How many hours of sleep do you get at night? _________________________

**Tuberculosis**

Do you know if you've had exposure to someone with TB? ☐ No ☐ Yes

Have you had previous TB tests? ☐ No ☐ Yes If Yes, Result: ________________

Have you had any treatment for positive TB test? ☐ No ☐ Yes

Have you had any diagnosis of active TB? ☐ No ☐ Yes, treatment used ___________

Treatment lasted ______________ months

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# DaVita Medical Group - Medical Center Point

Exit 146
Garden of the Gods Rd.
Austin Bluffs Pkwy.
25
Nevada
N
W
E
S
Medical Ctr. Pt.
Union Blvd.
Gap Rd.
Exit 145
Fillmore
Templeton
Circle Dr.
Constitution

*map not to scale

## 1625 Medical Center Point

Located on the northwest corner of Fillmore & Union

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