PULMONOLOGY DEPARTMENT

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

DaVita Medical Group

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		

Do you have a history of:	Yes	No			Yes	No
Other Heart Problems				Thyroid problems		
Blood clots Heartburn				Diabetes 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

<u>Tuberculosis History</u>

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):

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

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)

Please list any medications to which you are allergic:

PULMONOLOGY DEPARTMENT

PULMONARY MEDICINE-REVIEW OF SYSTEMS (MALE)

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

DaVita Medical Group

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

Eyes

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

Ear, Nose, Throat

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

Cardiovascular

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

Respiratory

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

Gastrointestinal

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

Genitourinary

☐ Pain with urination	☐ Slow starting urine	☐ Sores on penis or nearby skin
☐ Urine leaking	☐ Pain in testicles	☐ Urinating frequently at night

Musculoskeletal

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

Integumentary

☐ Abnormal patch of skin	☐ Itching	☐ Dry skin
☐ Skin wound	☐ Change in a mole	☐ Any unusual growth or lump

Neurological

☐ Confusion	☐ Dizziness	☐ Weak or numb limb
☐ Seizures or convulsion	☐ Fainting	☐ 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	☐ Difficult erections

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

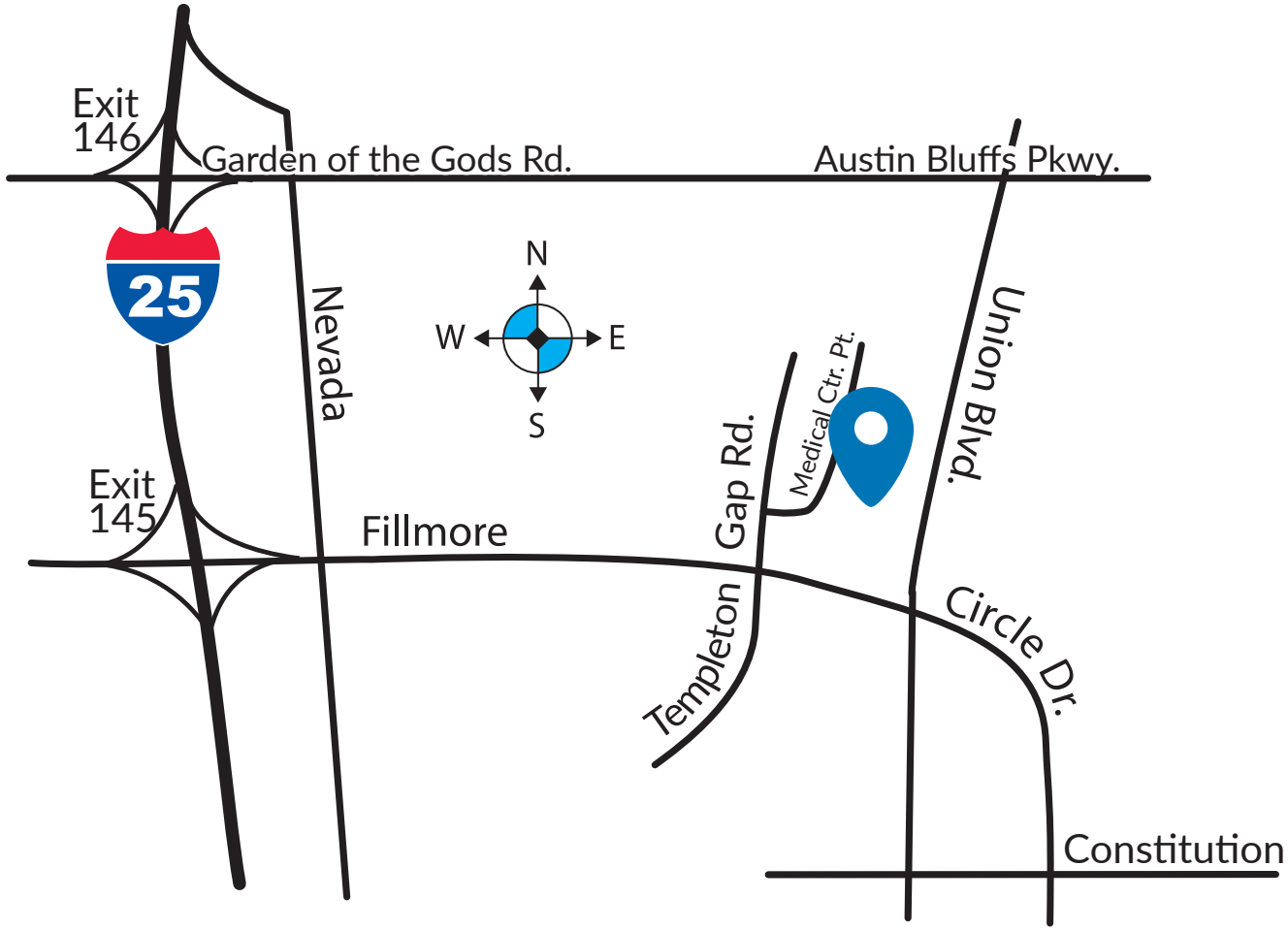
Have you had previous TB tests? ☐ No ☐ Yes If Yes, Result: _____

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

DaVita Medical Group - Medical Center Point



*map not to scale

1625 Medical Center Point

Located on the northwest corner of Fillmore & Union

DaVita Medical Group