

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

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:

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PULMONARY MEDICINE-REVIEW OF SYSTEMS (FEMALE)

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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

Psychiatric

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

Endocrine

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

Heme/Lymph

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

Other problems (please explain):

Sleep History

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

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

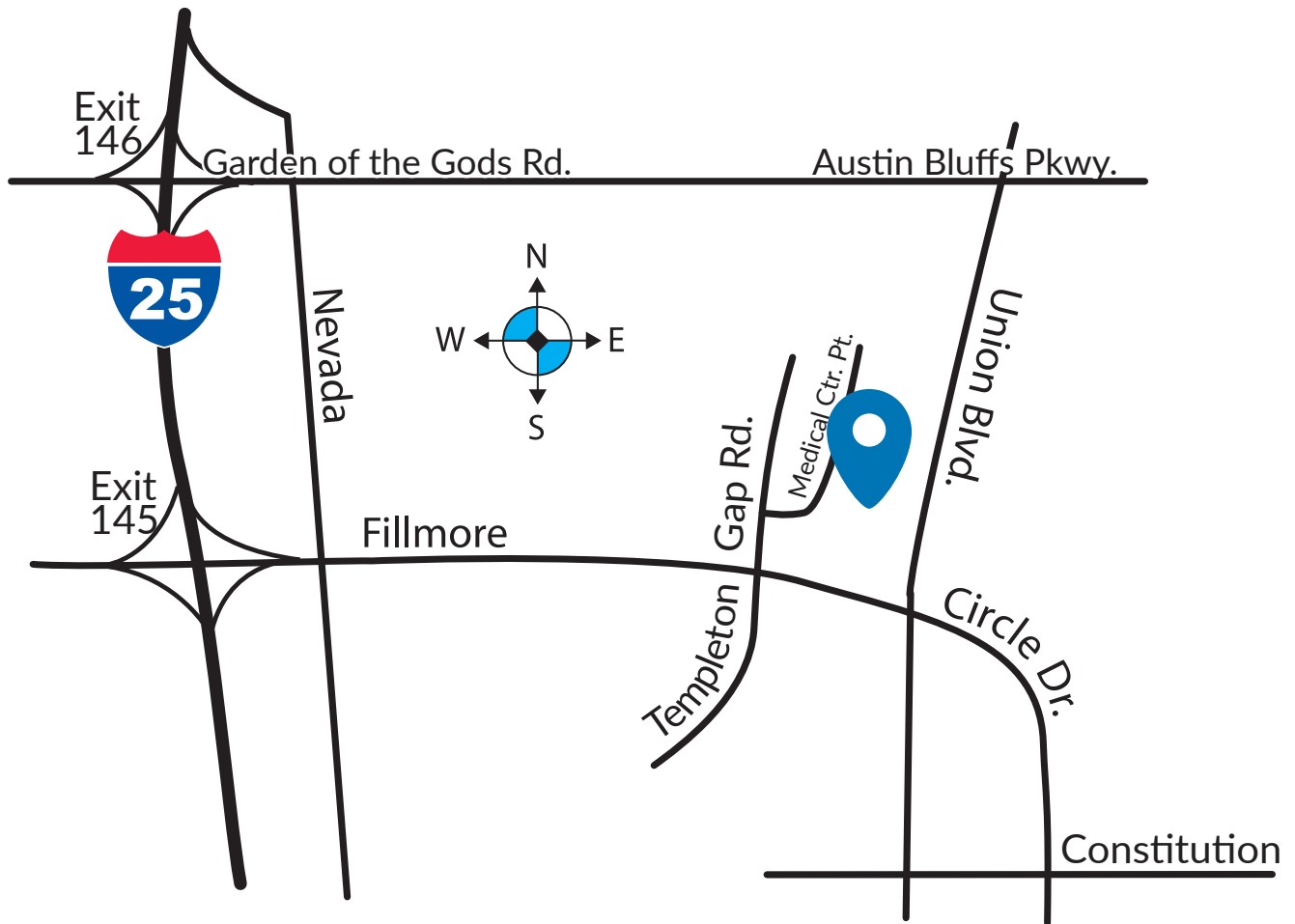
Have you had previous TB tests? No Yes If Yes, Result: _____

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

