Pulmonary and Sleep Medicine Consultants

Accredited by the American Academy of Sleep Medicine (AASM)

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Name: ____________________________________   **Date**: _____________

DOB: _____________   **Sex**: M F

Pulmonary Questionnaire

Check if applicable:

Symptom	X
Cough	
Shortness of breath	
Coughing up blood	
Recent bronchitis	
fever	
Unexplained weight loss	
Hoarseness of voice	
Unexplained gasping awakenings	
wheezing	
Swelling of the legs	
Joint pain	
Headaches	
History of reflux	
History of sinus problems	

Have you ever had any of these tests?
Circle if applicable: Pulmonary Function Test   Chest X-Ray   Labs

Additional concerns/comments: ____
____

Please leave blank *(to be filled out by doctor)*:

Assessment:
____
____

Plan:
____
____

Pharmacy:

FOR FOLLOW UP:

PMHx: circle if unchanged
PSHx: circle if unchanged

Continue maintenance medication: YES NO
Refills needed: YES NO
Check PFT's/CXR: YES NO

Follow up visit: 6 mo. 1 year