National Jewish Health
Breathing Science is Life.

▲ Please use blue or black ink

Patient Name: _____

Date of Birth: _____

(Patient Label)

ADULT PATIENT QUESTIONNAIRE

Please fax to 303-398-1211 or bring to your first appointment

Today's Date:_____/_____/_____

Your Cell Phone: (_____)_____

Emergency Contact Name:_____

Emergency Contact Phone: (_____)_____

Physician and Pharmacy Information

Primary Care Physician (Family Practice, Internist)

Name

Address

Phone

Fax

Email

Referring Physicians

Name

Address

Phone

Fax

Email

Other Physician/ Provider with Whom You Would Like Us to Communicate:

Name

Address

Phone

Fax

Email

Other Physician/ Provider with Whom You Would Like Us to Communicate:

Name

Address

Phone

Fax

Email

Preferred Retail Pharmacy

Name

Address

Phone

Fax

Mail Order/Alternate Pharmacy

Name

Address

Phone

Fax

What would you like to talk about during your visit?

_____

_____

_____

Medical History:

Past Medical History: Have you ever had any of the following?

Allergies	☐ Yes	☐ No	Irregular Heart Rhythm	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No	Kidney Failure or Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bone Fracture as an Adult	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Bronchiectasis	☐ Yes	☐ No	Mycobacterial Infection	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Obstructive Sleep Apnea	☐ Yes	☐ No
Cancer: _____	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
COPD	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No	Pulmonary Artery Hypertension	☐ Yes	☐ No
COVID	☐ Yes	☐ No	Pulmonary Embolism	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Pulmonary Fibrosis(**if yes, describe below**)	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Recurrent Infections	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
DVT	☐ Yes	☐ No	Sarcoidosis	☐ Yes	☐ No
Esophageal Disease	☐ Yes	☐ No	Scleroderma	☐ Yes	☐ No
GERD/Reflux	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Heart or Valve Defect	☐ Yes	☐ No	Sjogren's Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Skin Disorders (e.g., □Psoriasis,□ Acne)	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Shortness of Breath(**if yes, describe below**)	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No	Tuberculosis (**if yes, describe below**)	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No	Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No

Please list all other medical conditions past and present:

_____

_____

_____

Past Surgical History

Surgery or Procedure	Date of Procedure	Name of Surgeon/Provider

Vaccination/Immunization History

Vaccine/Immunization	Date of Last Immunization Month / Year
High Dose Flu Shot (Fluzone)	/
Flu Shot (Influenza)	/
Pneumovax (Pneumococcal Pneumonia-PPSV)	/
Prevnar (Pneumococcal Pneumonia-PneumoPCV)	/
Shingrix (Shingles or Herpes Zoster)	/
Tdap (Tetanus-Diptheria-Pertussis)	/
Zostavax (Shingles or Herpes Zoster)	/
1st Covid-19 □ Janssen □ Moderna □ Pfizer	/
2nd Covid-19 □ Janssen □ Moderna □ Pfizer	/
3rd Covid-19 Booster □ Janssen □ Moderna □ Pfizer	/
4th Covid-19 Booster □ Janssen □ Moderna □ Pfizer	/

Medications Taken Regularly

Include all oral, inhaled, intravenous, and subcutaneous medications as well as all herbal medications, supplements, vitamins and over-the-counter medications. If needed, please provide a separate list.

	Medication Name	Dose	Route (Oral, Inhale)	How Often?
ex	*Lipitor*	*10 mg*	*oral*	*Once daily*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				

Allergies

Allergic to: ☐ IV Contrast Dye: Type_____

Please list medication or severe food allergies	Describe reaction

Oxygen and Respiratory Equipment

1. Do you use oxygen? ☐ Yes ☐ No

   Amount: at rest_____ sleeping_____ with activity_____

   ☐ Nasal Cannula ☐ Mask ☐ Transtracheal

2. Do you use a☐ CPAP or ☐ Bi-PAP Settings:_____

3. What company delivers your oxygen or other medical equipment? _____

Family History

Indicate if your family members have any of these diseases (GM=Grandmother, GF=Grandfather, Maternal=Mothers's side Paternal=Father's side, Sis=Sister, Bro=Brother and Dau=Daughter).

Disease	**Maternal**			**Paternal**			**Siblings**			**Children**			
	Mom	GM	GF	Dad	GM	GF	Sis	Bro		Dau	Son		
Asthma													
Autoimmune Disease Type:													
Cancer Type **(specify in box):**													
□ COPD / □ Emphysema													
Coronary Artery Disease (CAD)													
Diabetes Mellitus													
Frequent Pneumonia													
Heart Attack													
High Blood Pressure													
High Cholesterol													
□ Interstitial Lung Disease / □ Pulmonary Fibrosis													
Pulmonary Embolism (PE)													
Rheumatoid Arthritis (RA)													
Stroke													
□ Osteoporosis/ □ Fragile Bones and/or □ Hip Fracture													
Other #1													
Other #2													
Other #3													

Other diseases that run in the family: _____

_____

_____

_____

_____

Social History

1. Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed

2. Smoking History: ☐ I have **never** smoked

   I currently smoke: ☐ Cigarettes packs/day (**circle one**): _____ ☐ Cigar ☐ Pipe ☐ eCigarettes ☐ Other: _____

   If you currently smoke, are you interested in quitting? ☐ Yes ☐ No

   I previously smoked: ☐ Cigarettes ☐ Cigar ☐ Other Age Started: _____ Age Stopped: _____

   Average packs/day (**circle one**): _____Are there smokers in home? ☐ Yes ☐ No

   Smokeless tobacco: ☐ Yes ☐ No Number of years: _____

3. Marijuana: ☐ Yes ☐ No Route: ☐ Inhaled ☐ Edible Medical: ☐ Yes ☐ No

4. Street/Illicit Drugs: ☐ Yes ☐ No If yes, which? _____

5. Alcohol Use: Any problems with alcohol now or in the past? ☐ Yes ☐ No

   Current number of drinks per week: _____ Type(s) of alcohol: _____

6. Exercise: Do you exercise regularly? ☐ Yes ☐ No

   Please Describe: _____

7. Fall Risk: Have you fallen in the past 3 months? ☐ Yes ☐ No
   Do you feel unsteady when standing? ☐ Yes ☐ No
   Do you use a cane, walker or wheelchair? ☐ Yes ☐ No
   Do you have a fear of falling? ☐ Yes ☐ No

Occupational History - Please start with the most recent job and work backwards

Job Title	Dates of Employment	Description	Health risks/exposures	Injuries/Illnesses

Review of Symptoms: What symptoms have you experienced in the last **6 months**?

General

Weight change	☐ Yes ☐ No
Fatigue (impairs daily function)	☐ Yes ☐ No
Fever/Chills	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No
Decreased Appetite	☐ Yes ☐ No

Eyes

Visual changes	☐ Yes ☐ No
Dry, irritated or painful eyes	☐ Yes ☐ No

ENT/Mouth

Ear pain or drainage	☐ Yes ☐ No
Frequent sinus infections/ sinus pain	☐ Yes ☐ No
Hearing changes or loss	☐ Yes ☐ No
Nosebleeds	☐ Yes ☐ No
Post Nasal Drip	☐ Yes ☐ No
Change in voice/ hoarseness	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No
Ulcers/Sores in the eyes, mouth or nose	☐ Yes ☐ No

Respiratory

Sputum Production	☐ Yes ☐ No
Chest tightness	☐ Yes ☐ No
Cough lasting >1 month	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No
Coughing up blood	☐ Yes ☐ No

Cardiovascular

Chest pain or heaviness	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No
Fainting or near fainting spells	☐ Yes ☐ No
Swelling of feet or legs	☐ Yes ☐ No
Shortness of breath lying flat in bed	☐ Yes ☐ No

Gastrointestinal

Abdominal pain	☐ Yes ☐ No
Blood in your stool	☐ Yes ☐ No
Constipation	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No
Heartburn or indigestion	☐ Yes ☐ No
Vomiting or nausea lasting >1 day	☐ Yes ☐ No
Swallowing difficulty	☐ Yes ☐ No

Allergic/Immunologic

Watery or itchy eyes	☐ Yes ☐ No
Runny nose	☐ Yes ☐ No
Food intolerance	☐ Yes ☐ No

Psychological

Anxiety without clear explanation	☐ Yes ☐ No
Sadness lasting days or weeks	☐ Yes ☐ No
Depression	☐ Yes ☐ No

Genitourinary

Blood in your urine	☐ Yes ☐ No
Urinating that is painful or difficult	☐ Yes ☐ No
Erection problems	☐ Yes ☐ No

Musculoskeletal

Joint pain or swelling	☐ Yes ☐ No
Muscle aches or tenderness	☐ Yes ☐ No
Muscle weakness	☐ Yes ☐ No
Stiffness in the joints	☐ Yes ☐ No
Ulcers on the fingertips	☐ Yes ☐ No

Skin

Hives	☐ Yes ☐ No
Rash	☐ Yes ☐ No
Non-healing ulcers	☐ Yes ☐ No
Skin cancer	☐ Yes ☐ No
Color change or coldness in fingertips	☐ Yes ☐ No
Other changes in skin	☐ Yes ☐ No

Neurologic

Seizures	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No
Extremity pain or burning sensation	☐ Yes ☐ No
Numbness or tingling	☐ Yes ☐ No

Endocrine

Frequent urination	☐ Yes ☐ No
Increased thirst	☐ Yes ☐ No
Heat or cold intolerance	☐ Yes ☐ No
Menstrual changes	☐ Yes ☐ No

Hematological/Lymphatic

Inappropriate bleeding	☐ Yes ☐ No
Unexplained bruising	☐ Yes ☐ No
Swollen/Painful lymph nodes	☐ Yes ☐ No

Sleep

Snoring	☐ Yes ☐ No
Do you stop breathing at night?	☐ Yes ☐ No
Excessive Daytime Sleepiness	☐ Yes ☐ No
Falling asleep when you should not	☐ Yes ☐ No
Difficulty falling or staying asleep	☐ Yes ☐ No

Thank you for completing our questionnaire. Please be advised that completing preliminary health questionnaires does not establish a physician-patient relationship with National Jewish Health. This relationship begins at the time of your initial visit to our clinics, after we review your health history and conduct an initial evaluation.