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Pulmonary/Sleep Supplemental Health Questionnaire

Welcome to Paloma Medical Group. Please complete the general health questionnaire form and pulmonary/sleep supplemental health questionnaire if you have an appointment with the pulmonologist or sleep specialist.

Name____ Today's date __ _ _ _/ _ _ _ _/_ ________

What is your main complaint today? ___________________How long have you had this problem? ________

History of coughing

Do you wake up in the morning coughing? ☐ Yes ☐ No If yes, how often? _____________
Do you frequently cough in the morning? ☐ Yes ☐ No
Do you cough throughout the day? ☐ Yes ☐ No
Do you wake in the night coughing? ☐ Yes ☐ No If yes, how often? ______________

History of Wheezing

Do you wheeze or feel chest tightness, in the morning? ☐ Yes ☐ No If yes, how often? _______
Do you wake in the night wheezing? ☐ Yes ☐ No If yes, how often? _______
Do you use inhaler or nebulizer to relieve night or morning symptoms? ☐ Yes ☐ No
If yes, how often? __________________ Name of medication: __________________________

History of Congestion

Do you have mucus in your chest/throat when you cough? ☐ Yes ☐ No If yes, how often? __________

Exposure to dust or fumes

Have you ever been exposed to fumes, dusts or solvents? ☐ Yes ☐ No If yes, what kind? __________

History of Shortness of breath

When you wake in the morning, are you short of breath? ☐ Yes ☐ No If yes, how often? __________
Do you wake in the night, short of breath? ☐ Yes ☐ No
Do you feel short of breath while resting? ☐ Yes ☐ No
Do you feel short of breath during strenuous exercise? ☐ Yes ☐ No

Environmental History:

Have you ever been exposed to any harmful substances? ☐ Yes ☐ No
Name of Harmful Substance # of years

Sleeping problems

Excessive daytime sleepiness ☐ Yes ☐ No Snoring ☐ Yes ☐ No
A.M. Headaches ☐ Yes ☐ No Difficulty Sleeping ☐ Yes ☐ No
Witnessed apnea (someone has reported you stop breathing during sleep) ☐ Yes ☐ No

SIGNAGURE: (PATIENT OR PARENT IF MINOR) ______________________ **DATE:** __________________

Print name: ____ **Date of Birth:** ____________________