National Jewish Health®
Science Transforming Life®

Patient Name: ____________________
Date of Birth: ____________________
Cell Phone: (_____)____________________

▲ **Please use blue or black ink**

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?

Condition	Yes	No	Condition	Yes	No
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	Obstructive Sleep Apnea	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cancer (**if yes, describe below**)	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Pulmonary Artery Hypertension	☐ Yes	☐ No
Coronary Artery Disease/Heart attack	☐ Yes	☐ No	Pulmonary Fibrosis(**if yes, describe below**)	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Recurrent Infections	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sarcoidosis	☐ Yes	☐ No
DVT or Pulmonary Embolism	☐ Yes	☐ No	Scleroderma	☐ Yes	☐ No
Esophageal Disease	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
GERD/Reflux	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Heart or Valve Defect	☐ Yes	☐ No	Sjogren’s	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Skin Disorders (e.g., Psoriasis, Acne)	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Tuberculosis (**if yes, describe below**)	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Mycobacterial Infection	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No	Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ 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
Flu (Influenza) Shot	/
High Dose Flu Shot	/
Pneumovax (Pneumococcal Pneumonia)	/
Prevnar (Pneumococcal Pneumonia)	/
Zostavax (Shingles or Herpes Zoster)	/
Tdap (Tetanus-Diptheria-Pertussis)	/
Other:	/

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				
15				

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=mother, Paternal=father's side)

Disease	Maternal			Paternal			Siblings			Children			
	Mom	GM	GF	Dad	GM	GF							
Asthma													
Autoimmune Disease Type:													
Cancer Type:													
COPD/ Emphysema													
Pulmonary fibrosis/ Interstitial Lung Disease													
Coronary artery disease/heart attack													
Diabetes Mellitus													
High cholesterol													
High blood pressure													
Frequent Pneumonia													
Pulmonary embolism (PE)													
Rheumatoid arthritis													
Stroke													
Osteoporosis/ Fragile Bones and/or Hip Fracture													
Other #1													
Other #2													

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: _______ ☐ 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: _____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.