CEDARS-SINAI®

DEPARTMENT OF MEDICINE, PULMONARY DIVISION
Advanced Lung Disease Program
8723 Alden Drive, Suite 260 East • Los Angeles, CA 90048
Office (310) 423-4685 • Fax (310) 310-423-2665

PATIENT I.D.

NEW PATIENT HISTORY

Please complete and bring with you to your appointment.

Name: ______________________ Date: ______________________

Address: ______________________ Telephone 1: (______)______________

______________________ Telephone 2: (______)______________

Referring Physician ______________________ Primary Physician ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Why did you come to clinic today? ______________________

What would you like to accomplish today? ______________________

How long have you been short of breath? ______________________

Are you short of breath sitting at rest? ______________________

With exercise? ______________________

*** TO BE COMPLETED BY PHYSICIAN ***

History of Present Illness:

PHYSICIAN I.D. NUMBER	SIGNATURE OF PHYSICIAN	DATE	TIME
	M.D.		

Do you use Oxygen at Rest: ❑ Yes ❑ No ______ L/min

Do you use Oxygen use with walking: ❑ Yes ❑ No ______ L/min

Date and location of lung biopsy: ______________________

Date of first abnormal CXR:______________________

NAME OF HPI (please print)	SIGNATURE OF HPI	DATE	TIME

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List your current medications (including inhalers) and their doses:

Name of Medicine	Dose	How Often	How long have you been taking it?

Do you take any herbal medicines, vitamins, and/or over the counter medicines? ❑ Yes ❑ No
Please list: ____________________

Have you ever taken other medications for your lung disease? ❑ Yes ❑ No
Please list: ____________________

Have you ever taken steroid medications (Prednisone)? ❑ Yes ❑ No

____

Approximate date of first prednisone use:

____

What side effects did you have from Prednisone?

____

Did it help? ____________________

Are you allergic to any medications?

Name of Medicine	Type of reaction you had

Other Allergies? ❑ Yes ❑ No ____________________

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Do you have a flu shot every fall? ❑ Yes ❑ No When was your last one? ___________________

Have you ever had the pneumonia vaccine? ❑ Yes ❑ No Date: ___________________

Past Medical History

List your current health problems.

List problems which are resolved

1.
2.
3.
4.

Previous Surgeries:

Surgery	Year

Family History

Relative	Age	Health Problems	Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			

Does anyone in your family OTHER THAN YOU have

Clubbing (spoon shaped finger nails)? ❑ Yes ❑ No ❑ Not sure
Pulmonary Fibrosis? ❑ Yes ❑ No ❑ Not sure
Rheumatoid Arthritis? ❑ Yes ❑ No ❑ Not sure
Lupus? ❑ Yes ❑ No ❑ Not sure
Sarcoidosis? ❑ Yes ❑ No ❑ Not sure
Scleroderma? ❑ Yes ❑ No ❑ Not sure

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Social History:

Are you married? ❑ Yes ❑ No single? ❑ Yes ❑ No divorced? ❑ Yes ❑ No
widowed? ❑ Yes ❑ No significant other? ❑ Yes ❑ No domestic partner? ❑ Yes ❑ No
How many years? __________
Do you have Children ❑ Yes ❑ No If Yes, Number of children? __________

Tobacco: Did you ever smoke? ❑ Yes ❑ No How many packs/day? ______________
How many years? ___________ When did you quit? ___________
If you haven't, would you consider it? ❑ Yes ❑ No

Alcohol: Do you use alcohol? ❑ Yes ❑ No
How many drinks/day (estimate): ____________
How many drinks/week? _______________ What type do you prefer? _________________
Has it ever been a problem? ❑ Yes ❑ No

Any unusual travel experiences? ____

Pulmonary Fibrosis Patient Questionnaire

Job History:

Please list all of your jobs starting with your current as Job#1 and working backwards chronologically. If you worked in the same kind of job for different employers you can list them as one job.

Job	Job Title/Occupation	Type of Industry	Year Began	Year Ended
#1				
#2				
#3				
#4				
#5				

Hobbies/Recreational Activities:

Please list all hobbies and recreational activities you currently participate in (examples: painting, furniture refinishing, sewing/crochet/needlework, woodworking, animal rearing, etc.) and estimate the number of hours per month devoted to each.

	Hobby or Activity	Hours per Month
1.		
2.		
3.		
4.		

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Do you live in a ❑ house, ❑ apartment or ❑ trailer?

How old is it? ______________________________

Does it have a basement? ❑ Yes ❑ No

Does it have a crawl space? ❑ Yes ❑ No

Is your home damp? ❑ Yes ❑ No

Is there or has there ever been mold in your home? ❑ Yes ❑ No

Do you own an indoor hot tub? ❑ Yes ❑ No

Do you have any pets? ❑ Yes ❑ No

Have you worked on a farm? ❑ Yes ❑ No

Do you have any house birds? ❑ Yes ❑ No

Chickens? ❑ Yes ❑ No

Pigeons? ❑ Yes ❑ No

Exposures

Using the jobs and the jobs numbers you previously described, please indicate if you were exposed to any of the following agents and the level of exposure.

Were you exposed to DUST(S)? ❑ Yes ❑ No

Type of Dust	Exposed?		Amount of Exposure			Job #
	Yes	No	Low	Med	High	
Grain						
Hay						
Asbestos						
Sillca (e.g. sand)						
Mica/Feldspar						
Coal						
Rock Dust						
Clay/Ceramic						
Fiberglass						
Wood						
Cotton						
Other (Specify)						

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Were you exposed to FUMES? ❑ Yes ❑ No

Type of Fume	Exposed?		Amount of Exposure			Job #
	Yes	No	Low	Med	High	
Welding						
Metal						
Plastic						
Other (Specify)						

Were you exposed to GASES? ❑ Yes ❑ No

Type of Gas	Exposed?		Amount of Exposure			Job #
	Yes	No	Low	Med	High	
Hydrogen sulfide						
Sulfur oxides						
Nitrogen oxides						
Carbon Monoxide						
Ozone						
Ethylenne Oxide						
Other (Specify)						

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Were you exposed to ELEMENTS and METALS? ❑ Yes ❑ No

Type of Elements and Metals	Exposed?		Amount of Exposure			Job #
	Yes	No	Low	Med	High	
Arsenic						
Cadmium						
Chromium						
Copper						
Lead						
Mercury						
Beryllium						
Hard Metal (e.g. Carbide Tungsten)						
Nickel						
Zinc						
Other (Specify)						

Were you exposed to other CHEMICALS? ❑ Yes ❑ No

Type of Chemical	Exposed?		Amount of Exposure			Job #
	Yes	No	Low	Med	High	
Acids						
Alkali (Caustics)						
Ammonia						
Detergents & Soaps (specify)						
Dyes						
Pesticides (specify)						
Herbicides (specify)						
Rodenticides (specify)						

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Type of Chemical	Exposed?		Amount of Exposure			Job #
	Yes	No	Low	Med	High	
Formaldehyde (specify)						
Resins						
Other (Specify)						

Have you ever taken any of these medications?

Methotrexate/ Trexall ❑ Yes ❑ No

Bleomycin/ Blenoxane ❑ Yes ❑ No

Amiodarone/ Cordarone/ Pacerone ❑ Yes ❑ No

Nitrofurantoin/ Macrobid/ Macrodantin/ Furadantin ❑ Yes ❑ No

BCG Therapy (intravesical) ❑ Yes ❑ No

Busulfan/ Myleran ❑ Yes ❑ No

Carmustine (BCNU) ❑ Yes ❑ No

L-tryptophan ❑ Yes ❑ No

Have you ever been diagnosed with cancer? ❑ Yes ❑ No If so, what kind?

___

Did you receive radiation as treatment? Cancer Radiation? ❑ Yes ❑ No

___

Review of Health (please circle/answer all that apply):

General:

Overall health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Usual Weight: ______________________________

Recent weight changes? ❑ Yes ❑ No

Fatigue? ❑ Yes ❑ No

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Skin: • Rash on face with sun exposure? • Skin bumps? • Any rash? • Change in hand color in the cold?	 ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No	***Comments:***
Neurology: • Headache, head injury?	❑ Yes ❑ No	***Comments:***
Eyes: • Vision change, pain, redness, dry eyes requiring eye drops?	❑ Yes ❑ No	***Comments:***
Ears: • Hearing change, ear ache, infection, discharge?	❑ Yes ❑ No	***Comments:***
Nose/Sinus: • Frequent colds, congestion, drainage, itching, nosebleeds?	❑ Yes ❑ No	***Comments:***
Mouth: • Changes in teeth, gums, bleeding, sore tongue/throat, dry mouth requiring liquids to eat and swallow?	❑ Yes ❑ No	***Comments:***
Neck: • Lumps, pain, stiffness?	❑ Yes ❑ No	***Comments:***
Chest: • Cough, phlegm, coughing up blood wheezing? • Shortness of breath with: exercise, at rest, after going to bed? • How many pillows do you sleep on?	 ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No	***Comments:***

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Heart: • Chest pain, high blood pressure, swelling in legs, pain in legs with exercise, awaken from sleep short of breath?	❑ Yes ❑ No	***Comments:***
Stomach: • Heartburn, change in appetite, indigestion, constipation, food sticks when swallowing, diarrhea, bleeding, hemorrhoids?	❑ Yes ❑ No	***Comments:***
Urinary: • Frequent voiding, incontinence, blood in urine?	❑ Yes ❑ No	***Comments:***
Joints/muscles: • Morning stiffness, joint swelling, tenderness, weakness, limited motion in limbs, difficulty standing from a chair, difficulty reaching overhead?	❑ Yes ❑ No	***Comments:***
Sleep quality: • Snoring, awaken abruptly, sleep all day, early AM headaches?	❑ Yes ❑ No	***Comments:***
Bones: • Back pain, hip pain? • Have you had a bone density scan?	❑ Yes ❑ No ❑ Yes ❑ No	***Comments:***

NAME (please print)		SIGNATURE	DATE	TIME
STAFF REVIEWER (please print	TITLE	SIGNATURE OF STAFF REVIEWER	DATE	TIME