UAB Interstitial Lung Disease Program
New Patient Medical History Form

Name: _____

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Referring/Consulting Physician Information (If applicable)

Name: _____ Location: _____

Phone: ( ) _____ Fax: ( ) _____

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1. What is the reason for your visit? _____

_____

2. Check the single number that describes the point at which you become short of breath:

_____1. I am not troubled with breathlessness except with strenuous exercise.

_____2. I get short of breath when hurrying on level ground or walking up a slight hill.

_____3. I walk slower than people of my age on level ground because of breathlessness or I have to stop from breath when walking on my own pace on level ground.

_____4. I stop for breathe after walking about 100 yards (90 meters) (or after a few minutes) on level ground.

_____5. I am too breathless to leave the house or breathless on dressing or undressing.

3. How did your shortness of breath begin? ____Suddenly ____ Gradually

4. How long have you had shortness of breath? _____ Years _____ Months

5. How often do you cough? (Do not include clearing your throat.)
_____ Not at all, or only rarely
_____ Occasionally, but not bothersome
_____ Most days
_____ Often or in severe attacks that interfere with activity

6. How long have you been coughing? _____ Years ____ Months _____Not applicable

7. Do you cough at night? Yes ____ No ____

7.1 If you cough at night, does it awaken you? Yes ____ No ____

8. The cough produces: (Check all that apply.)

_____ No phlegm ____ Phlegm _____ Blood _____ Don’t cough

9. Does your chest ever sound wheezy or whistling? Yes___ No ___

9.1 If “yes”, for how long? ____Years _____Months

Medical History Check all that apply

Has a doctor ever told you that you have:

_____Heart disease
_____Thyroid disease
_____Diabetes
_____Sinus disease
_____Stroke
_____Seizure
_____Eye inflammation
_____Mononucleosis
_____Hepatitis B or C
_____Tuberculosis
_____Kidney disease
_____Kidney stones
_____Blood in urine
_____Pleurisy
_____Pneumonia
_____Asthma
_____Blood clots
_____Pulmonary hypertension
_____Heart failure (“Fluid on the lungs”)

Have you noticed any?

_____Weight loss
_____Difficulty swallowing
_____Heartburn or reflux
_____Dry eyes or dry mouth
_____Rash or change in skin
_____Foot or leg swelling
_____Sensitivity to light
_____Bruising
_____Hand ulcers/sores
_____Mouth ulcers/sores
_____Chest pain
_____Joint pain or swelling

Have you had any of the following medical problems?

___ Pneumothorax (collapsed lung)
___ Bleeding disorder
___ Vasculitis (inflammation of the blood vessels)
___ Raynaud’s phenomenon (fingers painful and turning colors on cold exposure)
___ Rheumatologic disease (This includes rheumatoid arthritis, lupus, scleroderma, mixed connective tissue disease, Sjogren’s Syndrome, Wegener’s, Polymyositis or dermatomyositis, Behcet’s disease, Ankylosing spondylitis.)
___ Bowel disease (This includes Crohn’s Disease, Ulcerative colitis, Primary biliary cirrhosis, celiac or Whipple’s disease.)

List any surgeries/operations you have had and the approximate dates:

Surgery	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

List all medications (including over-the-counter and herbal) you are currently taking. Please include dose and how often you take the medication.

Drug	Dose	Instructions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Have you ever been given any of these drugs/treatments?

Anti-inflammatory medications:
____ Azathioprine (Imuran)
____ Chlorambucil
____ Colchicine
____ Gold salts
____ Interferon (any)
____ Methotrexate
____ Penicillamine
____ Prednisone

Cancer therapy
____ Busulfan
____ Bleomycin
____ Cyclophosphamide
____ Etoposide
____ GMCSF
____ Mitomycin
____ Nilutamide
____ Nitrosoureas
____ Radiation
____ Vinblastine

Miscellaneous medications:
____ Fenfluramine/ dexfenfluramine (Fen/Fen)
____ Leukotriene inhibitor (Singulair, Accolate)
____ L tryptophan
____ Bladder BCG

Antibiotics/ infection treatment:
____Cephalosporin
____ Isoniazid (INH)
____ Macrolide
____ Minocycline
____ Nitrofurantoin (Macrodantin)
____ Penicillin
____ Sulfonamides/Sulfa drugs (TMP-SMX)

Cardiovascular medications:
____ Amiodarone (Cordarone)
____ Captopril (Capoten)
____ Hydralazine
____ Hydrochlorothiazide
____ Procainamide (Procain SR)
____ Sotalol

Gastrointestinal medications:
____ Azulfidine
____ Sulfasalazine

Neurological medications:
____ Bromocriptine
____ Carbamazepine (Tegretol)
____ Propylthiouracil
____ Phenytoin (Dilantin)

5. List all medications to which you are **ALLERGIC** or have had a reaction. Describe reaction, if known.

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

6. List the date of your most recent immunizations (shots):

Influenza (Flu shot) _____ Pneumonia (Pneumovax) _____

Family History and Habits

1. Does any member of your immediate family (parents or siblings) have a history of lung disease, autoimmune disease or cancer? If so, please describe.

_____

_____

2. Did you ever smoke tobacco? _____ yes _____ no

If yes: How old were you when you started smoking? _____

How many packs a day do (did) you smoke? _____

Are you still smoking now? _____ yes _____ no

If you are no longer smoking, how old were you when you quit? _____

3. Do you drink alcoholic beverages? _____ yes _____ no

If yes: What and how much do you drink? _____

4. Have you ever smoked, inhaled, or injected “recreational”drugs?
(Include “street drugs” or crushed pills. Do not include prescribed inhalers.)
_____ yes _____ no What kind?

_____

_____

5. Do you have any religious or cultural practices that may alter or affect your care?

_____

_____

Household/Workplace Characteristics

Have you lived in an old house within the past 10 years? ___ Yes ___ No

Does your current or past home or work place have any of the following? (Mark all that apply)

_____Humidifier
_____Sauna
_____Hot tub/Jacuzzi
_____Birds (Include pigeons, doves parakeets, cockatiels, chickens, ducks, geese, pheasants)
_____Water damage
_____ Mold/Mildew
_____ Animals

Have you used pillows or comforters stuffed with feathers? ___Yes ___ No

Work History/Exposures

1. Have you lived or worked in environment where you were exposed to heavy smoke or dust?
___ Yes ___No

2. Occupational history:
Please include all occupations in your life:

Occupation	Years worked	Exposures (Dust, metal, paint, fine particles, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Have you ever performed any of the following occupations?

____ Farm work
____ Painter
____ Sand blaster
____ Pipe fitter
____ Automotive mechanic
____ Welder
____ Insulator
____ Vineyard worker
____ Carpenter
____ Laboratory worker
____ Longshoreman

4. Have you ever worked in any of the following locations?

____ Mine
____ Quarry
____ Pulp mill
____ Bakery
____ Foundry
____ Railroad
____ Paper mill
____ Smelting
____ Plastic factory
____ Tunnel construction

5. Have you ever been exposed to the following at work/ home/ elsewhere?

Animals and Farming	Metals/Rocks	Food/Plant Production	Miscellaneous	Skilled
___Birds	___ Beryllium	___ Cheese	___ Cotton	___ Cork
___Feathers	___ Cobalt	___ Maple Bark	___ Wood	___ Detergent (isocyanates)
___Fishmeal	___Tin	___Wheat	___ Industrial Strength Cleaning Solution	___ Pottery
___Insecticide	___ Iron oxide	___Coffee/Tea		___ Talc
___ Fertilizer	___Aluminum	___ Mushroom	___ Oily Nose drops	___ Paint
	___ Mica	___ Oil		___ Cement
	___ Silica	___ Sugar cane		___ Pipes
	___ Asbestos	___ Malt		___ Brakes
	___ Coal	___Meat		___ Tile (Ceramic)

20. List any other unusual exposures that you feel might be related to your lung disease

_____

_____

_____

_____

_____

Review of Systems Questionnaire

Please check if you are experiencing any of the following symptoms or findings:

Review of Systems	Circle all that apply to you	Details
Constitutional	Lack of energy; snoring; loss of appetite; weight change; fever, sweats/chills	
HEENT	Double or blurred vision; glaucoma, cataracts; Hearing problems; buzzing or ringing in ears; allergies; hay fever; sinus problems; hoarseness or change in quality of voice	
Cardiac	Chest pain; palpitations; leg swelling; heart failure; passing out	
Respiratory/Sleep	Loud snoring; daytime sleepiness; breathing pauses or stop breathing while sleeping; wake up snoring or choking	
Gastrointestinal/Digestive	Heartburn/acid indigestion; Regurgitation; difficulty swallowing; nausea, vomiting; diarrhea; change in bowel habits; constipation; bloody or tarry stools, jaundice; liver disease; ulcers; gallstones	
Genitourinary	Burning; frequent urination; infections; kidney stones; nighttime urination; prostate problems; blood in urine; abnormal vaginal bleeding or menstrual periods; could you be pregnant?	
Musculoskeletal	Joint pains, swelling or redness; arthritis; back pain; muscle aches or tenderness; gout; osteoporosis	
Skin/Dermatological	Rashes; itching; moles; nail or hair changes	
Female Reproductive	Breast lumps; recent mammogram, pap smear and/or pelvic exam	
Neurological	Paralysis (even temporary); stroke; numbness; loss of balance; dizziness, difficulty swallowing or speaking; burning or tingling sensation; seizures; loss of memory; headaches; muscle weakness	
Psychiatric	Unusual thoughts; nervousness; crying or sadness; depression; suicide attempts; anxiety	
Endocrine	Thyroid disorder, intolerance to hot or cold temperatures; diabetes, increased thirst, hunger or urination; use of steroids	
Hematological/Lymphatic	Bleeding; easy bruising; anemia; cancer; risk factors for or HIV (AIDS); enlarged lymph nodes or glands. History of blood transfusion or transfusion reaction – when?	

Reviewed by: _____, M.D. Date: ____/____/_____