

▲ 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-Diphtheria-Pertussis)	/
Zostavax (Shingles or Herpes Zoster)	/
1 st Covid-19 ☐ Janssen ☐ Moderna ☐ Pfizer	/
2 nd Covid-19 ☐ Janssen ☐ Moderna ☐ Pfizer	/
3 rd Covid-19 Booster ☐ Janssen ☐ Moderna ☐ Pfizer	/
4 th 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	<i>Lipitor</i>	<i>10 mg</i>	<i>oral</i>	<i>Once daily</i>
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.