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: ( ) _____________________

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:

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<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
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</tbody>
</table>
List all medications (including over-the-counter and herbal) you are currently taking.
Please include dose and how often you take the medication.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Instructions</th>
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<tbody>
<tr>
<td>__________________________</td>
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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

**Antibiotics/ infection treatment:**
- Cephalosporin
- Isoniazid (INH)
- Macrolide
- Minocycline
- Nitrofurantoin (Macroban)
- Penicillin
- Sulfonamides/Sulfa drugs (TMP-SMX)

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

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

**Gastrointestinal medications:**
- Azulfidine
- Sulfasalazine

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

**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:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Years worked</th>
<th>Exposures (Dust, metal, paint, fine particles, etc)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Animals and Farming</th>
<th>Metals/Rocks</th>
<th>Food/Plant Production</th>
<th>Miscellaneous</th>
<th>Skilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>___Birds</td>
<td>___ Beryllium</td>
<td>___ Cheese</td>
<td>___ Cotton</td>
<td>___ Cork</td>
</tr>
<tr>
<td>___Feathers</td>
<td>___ Cobalt</td>
<td>___ Maple Bark</td>
<td>___ Wood</td>
<td>___ Detergent (isocyanates)</td>
</tr>
<tr>
<td>___Fishmeal</td>
<td>___ Tin</td>
<td>___ Wheat</td>
<td>___ Industrial Strength Cleaning Solution</td>
<td></td>
</tr>
<tr>
<td>___Insecticide</td>
<td>___ Iron oxide</td>
<td>___Coffee/Tea</td>
<td>___ Pottery</td>
<td></td>
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<tr>
<td>___Fertilizer</td>
<td>___ Aluminum</td>
<td>___ Mushroom</td>
<td>___ Talc</td>
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<tr>
<td></td>
<td>___ Mica</td>
<td>___ Oil</td>
<td>___ Oily Nose drops</td>
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<tr>
<td></td>
<td>___ Silica</td>
<td>___ Sugar cane</td>
<td>___ Paint</td>
<td></td>
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<tr>
<td></td>
<td>___ Asbestos</td>
<td>___ Malt</td>
<td>___ Cement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>___ Coal</td>
<td>___ Meat</td>
<td>___ Pipes</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>___ Brakes</td>
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<td>___ Tile (Ceramic)</td>
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</tbody>
</table>

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:

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

Reviewed by: ____________________________, M.D.    Date: ___/___/_______