PATIENT INFORMATION AND ASSESSMENT SHEET

Patient Name:_____ Date:_____ _____ _____

DOB:_____ _____ _____ Age:_____ Gender: ☐ M ☐ F

Referring Physician:_____ Diagnosis:_____ Age when Diagnosed:_____

PAST MEDICAL HISTORY

- In general, how would you rate your health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
- Have you ever attended a pulmonary rehabilitation before? ☐ Y ☐ N
- Over the past year, how many times have you been to the ER due to difficulty breathing? ☐ 0-1 ☐ ≥2
- What are some of the symptoms you feel most days? ☐ Shortness of Breath ☐ Cough ☐ Fatigue ☐ Other:_____ ☐ Sputum Production
- Have you had any surgeries that would prevent you from exercise? ☐ Y ☐ N

If yes, what type: ☐ Heart ☐ Other (explain): ☐ Back ☐ N/A ☐ Knee/Joint

- Are you taking any medications for breathing? (including prescription, over the counter, etc.) ☐ Y ☐ N

Name	Strength	Frequency	Name	Strength	Frequency

- Have you had your flu shot this year? ☐ Y ☐ N — Pneumonia in last 5 years? ☐ Y ☐ N
- Any Allergies? (medications, latex, foods, animals, etc.): ☐ NKDA ☐ Y:_____
- Which medical conditions do you have/been told you have?

☐ NONE ☐ Heart Failure ☐ Sleep Apnea ☐ Pulmonary Fibrosis
☐ Diabetes ☐ Lung Cancer ☐ Acid Reflux/GERD ☐ Pulmonary Hypertension
☐ COPD ☐ Asthma ☐ Sinusitis ☐ Pneumonia
☐ Emphysema ☐ Depression/PTSD ☐ Tuberculosis ☐ Vision or Hearing Problems
☐ Chronic Bronchitis ☐ Osteoporosis ☐ Cystic Fibrosis ☐ Other:_____

- Any family history of lung disease? ☐ Y ☐ N
  - Mother? ☐ Y ☐ N ☐ N/A Type:_____
  - Father? ☐ Y ☐ N ☐ N/A Type:_____
  - Siblings? ☐ Y ☐ N ☐ N/A Type:_____
- Do you have any documented learning difficulties? ☐ Y ☐ N
  If yes, please explain:_____
- Have you ever been/are regularly exposed to the following:
  ☐ Smoke ☐ Dust ☐ Asbestos ☐ Heavy Fumes (i.e. Paints/Plastics)? ☐ Mold ☐ Other:_____
  ☐ N/A

NUTRITION

- Have you recently lost weight without trying?
  ☐ Yes ☐ No (0) ☐ Unsure (2)
  If yes, how much? ☐ 2-13 (1) ☐ 14-23 (2) ☐ 24-33 (3) ☐ 34+ (4) ☐ Unsure (2)
  Do you ever have a decreased appetite due to trouble breathing? ☐ Yes (1) ☐ No (0)

MST Score:

BAR CODE

AS1461

SUMMERLIN HOSPITAL MEDICAL CENTER

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(PMM# 55824) (R 4/21) (FOD)

PATIENT IDENTIFICATION

DISEASE MANAGEMENT

- Do you have support at home? ☐ Y ☐ N
  - If yes, who? ☐ Spouse ☐ Child/Children ☐ Friend ☐ Other Caregiver ☐ N/A
- Who normally manages your lung disease? ☐ Primary MD ☐ Pulmonologist ☐ Other Healthcare Professional
- Do you use your maintenance medication(s) everyday? ☐ Y ☐ N ☐ N/A

  If not, why not? ☐ Forget ☐ Don't Need Them ☐ Can't afford them ☐ Other:_____ ☐ N/A
- Do you know the signs/symptoms of a lung infection? ☐ Y ☐ N
- Do you have an action plan to manage flare ups? ☐ Y ☐ N
- Have you ever had a spirometry (breathing test) done? ☐ Y ☐ N | If yes, when was the last time? ☐ <3mo ☐ >3mo
- Have you ever smoked cigarettes? ☐ Y ☐ N
  - If yes, what would/did you consider yourself? ☐ Regular Smoker ☐ Occasional Smoker ☐ Social Smoker
  - How many years have/did you smoked? ☐ 0-5 ☐ 5 to 10 ☐ 10 to 20 ☐ 20 to 30 ☐ >30 ☐ N/A
  - How many cigarettes per day? ☐ 0-5 ☐ 5 to 10 ☐ 10 to 20 ☐ 20 to 30 ☐ >30 ☐ N/A
  - Did you quit? ☐ Y ☐ N ☐ N/A | If yes, how many years ago?: ☐ N/A ☐ <1yr ☐ >1yr ☐ >5yrs ☐ >10yrs
    If no, would you like to? ☐ N/A ☐ Y ☐ N
- Do/have you use(d) any other nicotine/tobacco containing products? ☐ Y ☐ N

  If yes, type: ☐ Vapor/E-cigarettes ☐ Chew ☐ Other:_____ ☐ N/A
- Are/were you regularly exposed to smoke at work or home? ☐ Y ☐ N

  If yes, have you talked to them about quitting? ☐ Y ☐ N ☐ N/A
- Do you wear oxygen? ☐ Y: ☐ Continuous ☐ At night ☐ As Needed ☐ N

  If yes, what level do you normally have it set?_____L/min ☐ N/A
- Do you ever wake up at night due to trouble breathing? ☐ Y ☐ N
- Are you able to sleep with the head of bed flat? ☐ Y ☐ N | If not, is it due to breathing? ☐ Y ☐ N ☐ N/A
- Do you use any of the following home respiratory products? ☐ Y ☐ N
- If yes, which products do you use? ☐ CPAP ☐ Nebulizer ☐ Oxygen concentrator ☐ PEP Device ☐ BiPAP ☐ Chest Vest ☐ Inspiratory Muscle trainer ☐ N/A
- Do you exercise regularly? ☐ Y ☐ N | If yes, How often per week? ☐ 1-2. ☐ 3-4. ☐ 5-6. ☐ 7 ☐ N/A
  - What type of execise(s) do you do? ☐ Walk ☐ Gym ☐ Other:_____ ☐ N/A
- Do you have any pets? ☐ Y ☐ N

  If yes, what type? ☐ Dog(s) ☐ Cat(s) ☐ Other:_____ ☐ N/A
- Please state what goals you expect from the pulmonary rehabilitation program:

☐ Breath Better
☐ Increase endurance/stamina
☐ Control panic/anxiety
☐ Return to work
☐ Return to recreation/hobby
☐ Symptom Management
☐ Stop smoking/maintain cessation
☐ Weight loss
☐ Take medications correctly
☐ Other:_____

- Is there any thing I missed that you would like to share?

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