HIGHPOINT HEALTH
PULMONARY REHABILTATION PHASE II

Admission Profile

Date: ____________________

Diagnosis/ Date: ____

Referring Physician: ____________________ Phone: _______________ Fax: ________________________

Pulmonologist: __________________________ Phone: _______________ Fax:_________________________

Primary Care Physician: ________________Phone: _______________ Fax:_________________________

Emergency Contact / relationship: ____

Daytime Phone: _______________________________ **Cell phone:** _________________________________

Pulmonary History:

(Please check those that apply and list date of event/s):

( ) Asthma_______________________________________

( ) Chronic Bronchitis__________________________

( ) Emphysema /COPD__________________________

( ) Blood clot in lungs__________________________

( ) Cystic fibrosis______________________________

( ) Pulmonary fibrosis__________________________

( ) Lung transplant______________________________

( ) Tuberculosis_________________________________

( ) Pulmonary Embolism_________________________

( ) Pneumonia__________________________

( ) Sarcoidosis_________________________

( ) Collapsed lung______________________

( ) Lung Cancer________________________

( ) Pleurisy____________________________

( ) Bronchiectasis_______________________

( ) Interstitial Lung Disease______________

( ) Pulmonary Hypertension_____________

( ) Sleep Apnea_______________________

( ) Other____

Risk Assessment/ Focus List

Occupation: ______________________________ Retired? **Yes / No** Disabled? **Yes / No**

Marital status: **M / S / W / D / Separated** Children? ___________

My major source(s) of support (relationships): ____

Current Stressors? (Personal, financial, medical, etc.) ____________________

Patient's perception of stressors: None / Mild / Moderate / Severe

Family History of Pulmonary Disease? **Yes / No** **Explain:** __________________________________

PATIENT LABEL

Smoking History:

Do you currently smoke? **Yes / No** Type of tobacco use: **Cigarettes / Chew / Pipe / Cigars**

Number of years you have smoked? ____________ Average amount smoked per day. __________

If you use tobacco, do you plan to quit? **Yes / No When?** ________________________________

Have you ever tried tobacco cessation aides / attended support groups in past? **Yes / No**

Explain: ____

Exposure to secondhand smoke: **Yes / No** Currently live with a smoker: **Yes / No**

Activity Level / Exercise:

Current home exercise? **YES / NO** Type: ______________________________________

Number of days / week? ______________ Amount of time per session. ________________

Do you have any home exercise equipment? **YES / NO** Type equipment: ___________________

Has your physician limited your activities? **YES / NO** Explain: ____________________________

Do you have any hobbies or special interests?

The following things limit my ability to remain active:

_____ Shortness of breath _____ Lightheadedness _____ Fatigue _____ Vision _____ Hearing
_____ Joint problems (specify) __________________ Other: ________________________________

Sleep / Rest:

Any sleeping disorders? (Apnea, insomnia) ____

Average # hours of sleep / night? _____ Do you take naps? **YES / NO** How many? ____________

How many pillows do you sleep on at night? _______ Can you lay flat to sleep? **YES / NO**

Do you use a CPAP/ BiPAP machine at night? **YES / NO Number/ level:** __________________

Have you ever had a sleep study done? **YES / NO** When/Where? ___________________________

Alcohol Intake: Y / N Describe/amount:____

Caffeine Intake: Y / N Describe/amount: ____

PATIENT LABEL

Reading/Learning Ability

Able to Read/Write: Yes / No

I learn information best by _____ Explanation _____ Reading _____ Video
_____ Demonstration _____ Hands on _____ Computer

Highest level of education completed: ___Elementary ___ High School ____ Some college
____ College Graduate Other___________________________

Allergy / Vaccine History:

Any allergies? **( ) None ( ) Food ( ) Medications ( ) Environmental**

Explain: ____

Allergy triggers: ____ Dust ____ Smog ____Solvents ____ Humidity ____Perfumes/colognes
____ Rapid changes in weather ____ Tobacco smoke ____ Wind ____ Animals

How do you heat & cool your home? _______________

I receive the flu vaccine annually: **YES / NO** **Date:** ___________________________________

I have received the pneumonia vaccine. _____ **YES** _____ **NO** **Year received?** _______________
(Recommended every 5 years)

Have you been out of country in last 30 days? **YES / NO** **Where?** __________________________

Pulmonary History:

Cough? **YES / NO** **Mostly occurs:** ____Morning ____Evening ____ Night ____Around the clock

Mucus? **Yes / No** Color/ Amount/ Consistency: ____

I see my lung doctor every (time frame) ____6 months ____yearly ____as needed other_____________

Ever had any chest injuries/ surgeries? **YES / NO** Explain:__________________________________

How many pulmonary infections have you had in last year? _________

# of hospitalizations / ER visits in past year? _______ Last hospitalization?

Shortness of Breath:

My breathing is most difficult in:
____ Early A.M. ____Afternoon ____ Evening ____ Bedtime

PATIENT LABEL

I use the following to decrease or avoid being short of breath:

_____Stop and rest
_____ Use aerosol machine
_____ Use inhalers
_____ Use belly/diaphragm breathing
_____ Use a fan/air conditioner
_____ Open windows
_____ Remove myself from irritant
_____ Practice a relaxation technique
_____Avoid exposure to the irritants
_____ Check my peak flow
_____ Use pursed lip breathing
_____ Limit my activity
_____ Avoid tobacco smoke exposure

Respiratory Home Care Equipment History:

I use the following items:

_____ Peak flow meter
_____ Aerosol machine
_____ Suction machine
_____ Mechanical chest percussion
_____ PEP valve
_____ Spacer

Oxygen Use? Yes / No

- **Oxygen Flow rate:** ______ liters
- **System:** ____Concentrator ____ Liquid ____Tank ____ Pulse
- **Oxygen use**: _____ Continuously _____ Only as needed ____ With sleep only

How often do you change your oxygen tubing? ____

****My home care equipment vendor is**:____

I use the following to relax:

____Read ____Deep breathing ____Smoke ____TV
____Alcohol ____Yoga/Meditation ____Pursed lip breathing ____ Other: _________________

I affirm that I have provided the most accurate information and details that I can provide, regarding my medical history.

Patient Signature:______________________________ Date:________________

Remember to bring your completed forms with you on your first day of rehab. By having your forms completed, this will allow us to get the most out of each of your exercise sessions, beginning on your first day. Thank you for your cooperation and we look forward to working with you to improve your overall health and wellness.

PATIENT LABEL