Pulmonary Function Test Patient Questionnaire

Patient Name: ______________________________________________  Date: ________________________
Date of Birth: _________________
Height: _____________ inches
Weight: _____________ lbs.

Referring Physician: _______________________________________

HISTORY
Did you have any recent surgeries?  Type: ______________________________  Y  N
Have you ever had a pulmonary function test before?  Y  N
If YES, when was it done?  Approximate date: _____________
If YES, at what facility?  Name: __________________________
Have you had a respiratory infection such as the flue, bronchitis, pneumonia, or a chest cold within the last 6 weeks?  Y  N
What pulmonary or lung problems have you been diagnosed with?
  Asthma  Y  N
  Emphysema  Y  N
  Bronchitis  Y  N
  COPD  Y  N
  Other: ____________________  Y  N
Do you experience shortness of breath regularly?
  During exercise/activity?  Y  N
  Walking up stairs or incline?  Y  N
  During daily chores, bathing?  Y  N
  During rest and/or sleep?  Y  N
Do you have episodes of wheezing, whistling or chronic coughing?  Y  N
Do you have allergies or feel tightness in your chest when you breathe?  Y  N
Have you had exposure to lung irritants or carcinogens?
  Occupation: ___________________
  Do you have or ever had Tuberculosis (TB)?  Y  N
    Is it active?  Y  N

SMOKING
Do you currently or have you smoked?  Y  N
  If yes, how long? _____________
  How many packs a day? _____________
Have you ever been exposed to second hand smoke?  Y  N

MEDICATION
Have you used a Nebulizer or a MDI (Puffer) within the last 4-hours?  Y  N
Are you currently on long-lasting respiratory medication?  Y  N
Are you currently on any beta-blocker medication?  Y  N
List respiratory medications: __________________________________________

OTHER MEDICAL CONDITIONS: __________________________________________