

Pulmonary Function Questionnaire

NAME: _____ AGE: _____ HT: _____ WT: _____
KAISER MR#: _____ DAY PHONE: _____ DATE: _____

Occupational History:

1. Have you ever worked in any of the following? (please circle) Yes() No()
Shipbuilding mining road construction fireman
sandblaster plasterer Beautician in a quarry
in a foundry dusty jobs - Specify what: _____
How many years? _____
2. Have you ever changed occupations because of breathing problems? Yes() No()
Explain: _____

Illness Impact:

3. Have you ever been told that you have any of the following? (please circle) Yes() No()
Asthma emphysema chronic bronchitis pneumonia
TB pleurisy heart failure any other heart problems
4. Have you ever been told that you have had an abnormal chest x-ray? Yes() No()
5. In the past year, have you been hospitalized for any chest problems? Yes() No()
6. Have you ever had any chest, breast, or lung surgery? Yes() No()

Smoking History:

7. Do you smoke? Yes() No()
8. I have been smoking cigarettes _____ packs/day for _____ years
9. I quit smoking tobacco in _____ (year you quit). Prior to that, I smoked _____ packs/day
for _____ years. Pipe: _____ bowls/day for _____ years/or cigars/day for _____ years.

Wheezing:

10. Does your breathing ever sound wheezy? Yes() No()
11. What months do you wheeze most? _____
12. Have you ever had attacks of shortness of breath with wheezing? Yes() No()
13. I wheeze: (please circle) rarely occasionally regularly
14. Have you ever had any hay fever or any other allergy that makes your
nose run or stuffy, apart from colds? Yes() No()

Coughing:

15. How long have you been coughing? _____
16. Do you usually cough first thing in the morning? Yes() No()
17. Do you usually cough at other times during the day? Yes() No()
18. Do you cough on most days for as much as 3 months of the year? Yes() No()

Phlegm:

19. I bring up phlegm. Yes() No()
20. The color of the phlegm is: (please circle) white green yellow brown
red-streaked thick thin sticky plugs
21. Amount of phlegm/day:(please circle) teaspoonful tablespoonful cupful glassful

Breathlessness:

22. Are you troubled by shortness of breath when walking on level ground? Yes() No()
23. I get short of breath after walking less than:(please circle) 1 block 2 blocks
3 blocks 4 blocks 5 blocks
24. I have to stop to get my breath after climbing: (please circle) # of flights of stairs: 1 2 3
25. List the dosage, frequency and types of medications you are presently taking:

