HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PULMONARY FUNCTION TESTING QUESTIONNAIRE

To our patient: Please answer the questions below and sign your name at the end. Thank you!

1. Reason for today's test: _____
2. Have you ever smoked? ☐ Yes ☐ No
   If yes, what did you smoke? (check all that apply) ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Other: _____
   How many years did you smoke? _____ How many packs a day did/do you smoke? _____
   When did you quit smoking? _____
3. Do you get short of breath when:
   - Sitting ☐ Yes ☐ No
   - Walking normally ☐ Yes ☐ No
   - Climbing stairs ☐ Yes ☐ No
4. Do you have a daily cough? ☐ Yes ☐ No
5. Do you frequently cough-up mucous ☐ Yes ☐ No
6. Have *you* ever had a history of:

Emphysema	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	Bronchiectasis	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No

7. Do you have Sleep Apnea: ☐ Yes ☐ No
8. Have you had recent surgery of the chest or abdomen? ☐ Yes ☐ No
9. Have you ever had a breathing tube in your windpipe for surgery or to help you breathe? ☐ Yes ☐ No
10. Have you ever been exposed to dust, fumes, chemicals in a hazardous manner while at work or at home?
    ☐ Yes ☐ No If yes, please list your exposure: _____
11. What medications are you currently taking? _____
    _____
12. Have you ever had radiation or chemotherapy? ☐ Yes ☐ No
    If yes, please list medication or area of radiation: _____

_____ _____ _____ A.M./P.M.
[Patient Signature] [Date] [Time]

Date: _____ Ordering Physician: _____
BP: _____ HR: _____ SPO_2 _____% on_____ THB: _____ % CO _____ SAO_2 _____%
PRE-OP For: _____ Date of surgery: _____
PRE-OP Education: ☐ Intubation/ET Tube ☐ Incentive Spirometry ☐ Splinting ☐ Coughing/Deep breathing
Patient Position: _____ Repeatable Test? ☐ Yes ☐ No
RCP Comments: _____
RCP Print Name: _____ RCP Signature: _____

PATIENT HEALTH HISTORY

PS 4117 Rev 01/31/19

[4426]