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: _______________________________________

   ______________________   ______________________   ______________________
   [Patient Signature]        [Date]             [Time]

PRE-OP: ______________________     Ordering Physician: ______________________
BP: _____   HR: _____   SPO₂: _____% on _____   THB: _____% CO _____% SAO₂: _____%
PRE-OP Education: [ ] Intubation/ET Tube [ ] Incentive Spirometry [ ] Splinting [ ] Coughing/Deep breathing
Patient Position: ______________________
Repeatable Test? □ Yes □ No
Date of surgery: ______________________
RCP Comments: ______________________
RCP Print Name: ______________________
RCP Signature: ______________________

PATIENT HEALTH HISTORY
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