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!

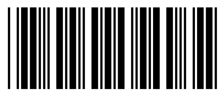
1. Reason for today's test: ______________________________
2. Have you ever smoked? ☐ Yes ☐ No
   If yes, what did you smoke? (check all that apply) ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Other: __________
   How many years did you smoke? __________ How many packs a day did/do you smoke? ____________
   When 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
   - Asthma ☐ Yes ☐ No
   - Wheezing ☐ Yes ☐ No
   - Bronchitis ☐ Yes ☐ No
   - Pneumonia ☐ Yes ☐ No
   - Heart Disease ☐ Yes ☐ No
   - Bronchiectasis ☐ 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] __________ A.M./P.M. [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



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