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: ________ A.M./P.M.

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: ____________________