Pulmonary Function/Spirometry Questionnaire

Patient Information

Patient Name	Date of Birth	Date

B/P _____ Pulse _____ Height _____ Weight _____

Questionnaire

1. Do you smoke?	☐ Yes	☐ No
If yes, have you smoked today?	☐ Yes	☐ No
2. Do you have asthma or other lung disease now or in the past?	☐ Yes	☐ No
If yes, have you used a breathing medicine in the last 6 hours?	☐ Yes	☐ No
Name of the medicine(s):		
3. Do you have a history of high or low blood pressure?	☐ Yes	☐ No
If yes, is it controlled?	☐ Yes	☐ No
Do you take medicine for your heart problem(s)?	☐ Yes	☐ No
4. Do you have heart disease- blockage, skip beats or valve problem?	☐ Yes	☐ No
If yes, is it controlled?	☐ Yes	☐ No
Do you take medicine for your heart problem(s)?	☐ Yes	☐ No
Name of the medicine(s):		
5. Have you had a head cold or sinus infection in the last week?	☐ Yes	☐ No
6. Have you had an ear infection in the last week?	☐ Yes	☐ No
7. Have you had surgery (including dental) in the last 60 days?	☐ Yes	☐ No
If yes, what was the surgery?		
8. Do you get dizzy or short of breath walking up an incline?	☐ Yes	☐ No
9. Have you ever done a pulmonary function or spirometry test?	☐ Yes	☐ No
If yes, were you told it was abnormal or normal?	☐ Normal	☐ Abnormal

Are there other things you want us to know before pulmonary function/spirometry testing?