CARDIOPULMONARY REHAB
PULMONARY QUESTIONNAIRE

Name:_____Date: _____
Diagnosis:_____
Primary Physician:_____ Pulmonologist:_____
Oncologist:_____ Cardiologist_____

Living Situation: House _____ Level :Single_____ Entrance Into Home: Steps_____
Apartment____ Multi_____ Incline_____
Mobile Home_____ Steps: Basement #_____ Flat_____
Condo_____ 2nd Story #_____

Household members:_____
(Relationship & name)_____
Household pets:_____
(Type & name)_____
Usual household duties I perform: ___Cooking ___Cleaning ___Grocery shopping
___Yard work ___Finances
___Laundry ___Transportation
My major source(s) of emotional support: (names and relationships)_____

Occupational History:
Current or former occupation:_____
If currently employed, skills/energy requirements for my occupation:_____
_____
Retirement/disability date:_____

Occupational exposure:
___Welding ___Pottery ___Gas/fumes
___Quarry ___Asbestos ___Mines/foundry
___Sandblasting ___Chemicals ___Dust

I learn information best by: ___Explanation ___Reading ___Video/TV ___Computer ___Demonstration

Medical History:
(Please check those that apply)

___ Sleep Apnea
___ Asthma
___ Chronic bronchitis
___ Emphysema
___ Bronchiectasis
___ Collapsed lung
___ Pneumonia
___ Tuberculosis
___ Sarcoidosis
___ Cystic fibrosis
___ Pulmonary fibrosis
___ Pulmonary Embolism (Clot)
___ Diabetes
___ Sarcoidosis
___ Pulmonary Hypertension
___ Congestive heart failure
___ Atrial fibrillation
___ High blood pressure
___ Heart disease
(Heart Attack; MI, Bypass, PTCA/STENT)
___ Stroke
___ Gastric Reflux
___ Sinus problems
___ Fractures (specify)_____
___ Osteoporosis
___ Arthritis
___ Depression
___ Cancer (specify)_____

Surgeries:_____
_____
_____
_____

Family history: (specify)_____
_____

Allergies:

I am allergic to the following:
Food(s):_____
Medications:_____
Environmental: ___Dust ___Mold ___Pollens ___Grass Other:_____

Allergies Cont.

I have difficulty when exposed to the following **environmental** irritants:

___Dust ___Humidity
___Rapid changes in temperature ___Tobacco smoke
___Solvents ___Wind
___Perfumes/colognes ___Smog
Other:_____

Vaccine History:

I receive the flu vaccine annually. Yes ___ No ___
If no, give reason why not:_____
I have received the pneumonia vaccine. Yes ___ No ___
Year received:_____
I have received a Tetnus vaccination: Date:_____

Smoking History:

___I have never smoked.
___I have smoked in the past but do not smoke now.
Year started_____ Year quit_____
Number of packs smoked per day_____
___I am currently a smoker : Cigarettes _____ Cigars _____
Number of packs smoked per day_____
___ Interested in Smoking Cessation When do you plan to quit?_____
___ Exposure to secondhand smoke: None ___Home ___Social situations ___Work___
___ I live with a smoker
___ I use chewing tobacco

Pulmonary Health History:

Cough: Yes ___ No___ A.M. ___P.M. ___Nighttime ___Around the clock___
Mucus: Normal color:_____ Thick ___Thin___
Amount/day: 1 tsp. ___1-2 tsp. ___1 Tbsp. ___1/4 cup ___1/2 cup ___1 cup ___>1 cup___
When: A.M. ___P.M. ___Around the clock ___
I use the following to help me raise my mucus:
___Drink warm liquids ___Inhalers
___Aerosol treatments ___Chest percussion
___Postural drainage ___Increase my fluids
I have coughed up blood. Yes ___ No ___
When:_____
I have taken steroid pills (e.g., Prednisone). Yes ___ No ___
I experience the following:
___Chest pain ___Dizziness/unsteadiness ___Hoarseness
___Fatigue ___Ankle swelling ___Weight change
___Wheezing ___A.M. ___P.M.
Known trigger factors:_____
I have been on a ventilator (respirator) in an intensive care unit. ___Yes ___No Last date:_____
I see my lung doctor every (please give a time frame):_____

Pulmonary Infections:

Number/year:_____
Antibiotic usually taken:_____
I know I have an infection when:_____

Pulmonary Hospitalizations:

Number in past year:_____

Emergency Room Visits for Pulmonary Reasons:

Number in past year:_____

Shortness of Breath:
I have experienced shortness of breath since:_____
My breathing is most difficult: Early A.M. ___ A.M. ___ P.M. ___ Bedtime ___
I use the following to decrease or avoid being short of breath:

___Stop and rest	___Use aerosol machine
___Use inhalers	___Use belly/diaphragm breathing
___Use a fan/air conditioner	___Open windows
___Remove myself from the irritant	___Limit my activity
___Practice a relaxation technique	___Avoid exposure to irritants
___Check the air pollution forecast	___Check my peak flow
___Use pursed lip breathing	___Avoid tobacco smoke exposure

Dietary History:

Current height:_____ Current weight:_____
I have recently had a change in my weight. Yes ___ No ___
Gained_____lbs. / Lost_____lbs.
Over this period of time_____
I can attribute this weight change to:_____
I would like to weigh_____lbs.
I follow the following type of diet:

___No special diet	___Diabetic
___Low sodium (salt)	___Ulcer
___Low cholesterol	___Hiatal hernia
___Low saturated fat	___Other_____
___Caloric restriction	

My appetite is: Good ___ Fair ___ Poor ___
I drink this amount of each of these a day:

Water_____	Sodas_____	Coffee_____
Tea_____	Wine_____	Hard liquor_____
Milk_____	Juice_____	Beer_____

I have difficulty with: chewing ___Yes ___No
swallowing ___Yes ___No
digestion ___Yes ___No
I take vitamins. ___Yes ___No
If yes, please list:_____

Activity/Exercise History:
Yes No I currently do purposeful walking/exercise ___days a week for ___ minutes.
Yes No I do calisthenics ___days/week.
The following things limit my ability to remain active:

___Shortness of breath	___Lightheadedness
___Fatigue	___Joint problems (specify):_____

Other:_____

I have the following exercise equipment available:

___None		
___Stationary bike	___Treadmill	___Stair-stepper
___Pool	___Weights	___Other:_____

Equipment/Assistive Device History:
I use the following items:

___Walker	___4 point/quad cane	___Electric cart
___Wheelchair	___Eyeglasses	___Other_____
___Cane	___Hearing aid	

Respiratory Home Care Equipment History:
I use the following items:

___Peak flow meter	___CPAP
___MDI	___BIPAP
___Spacer	___Nebulizer

Oxygen Yes ___ No ___ Start Date:_____
Home: Liquid_____Concentrator_____Liter Flow_____
Portable: Liquid_____Compressed(tank)_____Liter Flow_____
Continuous_____Pulse_____

Home Care Company:_____

Sleeping History:
Usual bedtime_____ Usual time of waking up_____
Naps take during the day: Number_____Length_____
Number of pillows used when sleeping_____
Medications/strategies used to help me sleep_____

Day to Day Living:

My present interests and hobbies are:_____
Former interests and hobbies in which I can no longer participate are:_____
This is what I do for fun:_____
Are you: Depressed___ Lonely___ Anxious___

Stress:
Current Stressors in your life:_____
Worries or concerns you are having:_____
How do you cope with your stress?_____

How do you relax:

___Read	___Alcohol	___Crossword Puzzles ___
___Deep breathing	___Yoga	___ Other:_____
___Smoke	___Pursed lip breathing	_____
___TV	___Tranquilizer	_____

What has been the most difficult adjustment since being diagnosed with a lung disease?_____
_____

My lung disease has affected about how I feel about myself: ____yes ____no. If Yes, explain:_____
_____.

My goals for completing pulmonary rehabilitation are:
1._____2._____
3._____4._____

Pulmonary questionnaire completed by: _____

ON DAY OF INTERVIEW:

PLEASE BRING:
ALL MEDICATIONS IN THEIR ORIGINAL BOTTLES
AND A LIST OF ALL MEDICATIONS
YOU ARE CURRENTLY TAKING!

IF YOU WERE MAILED ANY PAPERWORK, PLEASE FILL OUT AND BRING WITH YOU!