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

Family history: __________________________

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
- ___ Rapid changes in temperature
- ___ Solvents
- ___ Perfumes/colognes
- ___ Humidity
- ___ Tobacco smoke
- ___ Wind
- ___ 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!