Patient Label

ILD/DEOHS Questionnaire Addendum

These questions relate primarily to chest symptoms. Please check YES or NO, or check N/A if the question does not apply to you. If you are in doubt about whether your answer is YES or NO, record NO.

The following questions are designed to determine how much work would make you short of breath.

A. Is your activity limited by any condition other than your heart or lung disease?
☐ YES ☐ NO ☐ N/A

B. Circle which statement best describes your highest activity level on an average day.
   a. 30 minutes of vigorous activity
   b. 5 flights of stairs or 10 minutes of vigorous activity
   c. Walking 1-3 miles on level ground, or up 3 flights of stairs, or vigorous activity for less than 10 minutes, or heavy general labor
   d. Walking 1/4 to 1 mile on level ground or up 2 flights of stairs
   e. Walking 400 feet to 1/4 mile on level ground, or daily chores like bed-making
   f. Walking 150-300 feet on level ground or up 1 flight of stairs
   g. Walking 50-100 feet on level ground at a normal pace or doing light janitorial work
   h. Walking 20-50 feet on level ground or doing light standing work at your own pace
   i. Breathless just to leave the house or breathless on dressing or undressing, walking less than 20 feet, or prolonged talking
   j. Breathless with minimal activity (eating, using the restroom, writing, using small utensils)

C. How did your breathlessness begin? ☐ Suddenly ☐ Gradually ☐ N/A

D. Since your breathlessness started, has it:
☐ Worsened
☐ Stayed the same
☐ Improved

E. Which best describes you:
☐ Breathless all the time
☐ Repeat, sudden attacks of breathlessness
☐ N/A

F. How long have you had shortness of breath? _____ Years

Testing/Procedures:

When was the last time you have had any of the following testing?

Test	Approximate Date	Location
Pulmonary Function Testing		
Methacholine Challenge Testing		
Echocardiogram		
Left Heart Catheterization		
Right Heart Catheterization		
Bronchoscopy		
Lung Biopsy		
Polysomnogram (sleep study)		
Bone Density Testing		
Chest CT scan		

Environmental Exposures:

Type of home (i.e single family home, apartment, mobile home, etc)? _____

What is the setting of your home? ❑ Urban ❑ Suburban ❑ Rural

How many years have you lived in your home? _____

Age of your home? _____ (years)

Does your home have any of the following?

Basement	❑ Yes	❑ No	Mold	❑ Yes	❑ No
Central air heating/cooling	❑ Yes	❑ No	Mildew or musty odor	❑ Yes	❑ No
Evaporative (swamp) cooler	❑ Yes	❑ No	Humidifier	❑ Yes	❑ No
Fireplace or wood or coal stove	❑ Yes	❑ No	Sauna	❑ Yes	❑ No
Any previous water damage or flooding	❑ Yes	❑ No	Hot tub	❑ Yes	❑ No
Down or feather pillows/bedding/furniture	❑ Yes	❑ No	Swimming pool	❑ Yes	❑ No

During the three years prior to the onset of your respiratory symptoms, did you, or anyone living in your home ever have any of the following pets? If yes, please specify.

Dogs ❑ Yes ❑ No Birds ❑ Yes ❑ No

Cats ❑ Yes ❑ No Other (please specify) _____

Do you have any hobbies that might expose you to dusts or chemicals? ❑ Yes ❑ No

If yes, please explain: _____

Occupational History:

Have you ever worked in any mining, manufacturing, industrial, farming, or agricultural setting? ❑ Yes ❑ No

If yes, please explain: _____

During the three years prior to the onset of your respiratory symptoms, were you exposed to animals in your work? ❑ Yes ❑ No

Have you ever worked for a year or more in a dusty job? ❑ Yes ❑ No

Have you ever worked in any of the following occupations or locations? Have you ever had any of the following exposures? Please check all that apply:

Occupation:			**Misc:**	
	Farmer		Cotton	
	Painter		Wood	
	Sand Blaster		Industrial Strength Cleaners	
	Pipe Fitter/Coverer	**Ever Exposed To:**	**Skilled:**	
	Auto Mechanic		Cork	
	Welder		Isocyanates	
	Insulator		Pottery	
	Carpenter		Talc	
	Laboratory Worker		Paint	
Ever Worked These Locations:		**Food/Plant Production:**		Cement
	Mine		Pipes	
	Quarry		Brakes	
	Pulp Mill		Ceramic Tile	
	Bakery		Granite/Stone Cutting	
	Foundry		Epoxy Resins	
	Railroad			

Medication History:

Have you ever taken any of the Medications listed below to treat your lung disease?
IF YES: Please complete the information on dosage and date started/stopped.

Drug/Medication	Date Started	Date Stopped
Daily oral steroids (Prednisone, Medrol, Solumedrol, etc)		
Omalizumab (Xolair)		
Cyclophosphamide (Cytoxan)		
Azathioprine (Imuran)		
Mycophenolate (Cellcept)		
Methotrexate		
Rituximab (Rituxan)		
Pirfenidone (Esbriet)		
Nintedanib (Ofev)		
Infliximab (Remicaide), Adalimumab (Humira), Etanercept (Enbrel), or Golimumab (Simponi)		
Other immunosuppressive medication?		

Have you ever taken any of the Medications listed below? ☐ N/A

Cancer Chemotherapy (please list details below)	☐ Yes ☐ No
Radiation Therapy	☐ Yes ☐ No
Bleomycin	☐ Yes ☐ No
Nitrofurantoin (Macrobid/Macrodantin)	☐ Yes ☐ No
Doxycycline or minocycline or tetracycline	☐ Yes ☐ No
Phenytoin (Dilantin) or other anti-seizure medication	☐ Yes ☐ No
Hydralazine	☐ Yes ☐ No
Isoniazid or Carbamazepine (Tegretol)	☐ Yes ☐ No
Procainamide or Flecainide	☐ Yes ☐ No
Amiodarone	☐ Yes ☐ No
Sulfasalazine/Mesalamine	☐ Yes ☐ No
Penicillamine	☐ Yes ☐ No
Methotrexate	☐ Yes ☐ No
Sirolimus or everolimus	☐ Yes ☐ No
Fenfluramine or any weight loss medication	☐ Yes ☐ No
Propylthiouracil	☐ Yes ☐ No
Nonsteroidal anti-inflammatory (ibuprofen, naproxen, indomethacin, meloxicam, etc)	☐ Yes ☐ No
Any biologic therapy (Please list below)	☐ Yes ☐ No

Details: _____

Thank you for taking the time to complete this questionnaire. This information will help your doctor understand your complex medical condition(s) and will to facilitate your care. While the doctor will ask additional questions during your visit that may seem repetitive at times, please be assured that this is only to be sure we have a full and complete understanding of your health condition(s).