

Date of Birth : _____ Patient Name: _____

****Please print clearly and use black ink only.****

Appointment Date: _____

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		



Patient Label
XMRN: _____
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Right Heart Catheterization		
Bronchoscopy		
Lung Biopsy		
Polysomnogram (sleep study)		
Bone Density Testing		
Chest CT scan		

NSG 400 (6/15)

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

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

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)
- Radiation Therapy
- Bleomycin
- Nitrofurantoin (Macrobid/Macrodantin)
- Doxycycline or minocycline or tetracycline
- Phenytoin (Dilantin) or other anti-seizure medication
- Hydralazine
- Isoniazid or Carbamazepine (Tegretol)
- Procainamide or Flecainide
- Amiodarone

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

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|--|--|
| Sulfasalazine/Mesalamine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Penicillamine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Methotrexate | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sirolimus or everolimus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fenfluramine or any weight loss medication | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Propylthiouracil | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nonsteroidal anti-inflammatory (ibuprofen, naproxen, indomethacin, meloxicam, etc) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any biologic therapy (Please list below) | <input type="checkbox"/> Yes <input type="checkbox"/> 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).

Date	Time	Patient or Authorized Representative
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