



Desert Pulmonary & Sleep Consultants

SLEEP & DIAGNOSTIC CENTER
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Pulmonary Function Study Pre-Test Questionnaire

Name:		Today's Date:	
Doctor:		Birthdate:	

Height:	(inches)	Weight:	(pounds)
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1. Have you ever had a Pulmonary Function test performed? Yes No
If so, where and when? _____

2. Why were you referred for this test? (your diagnosis): _____

3. Have you ever smoked:

Cigarettes	Yes	No
Cigars	Yes	No
Pipe	Yes	No
Other	Yes	No

If so, how many years have you smoked? _____. How many cigarettes per day?
_____. Do you still smoke? Yes No. What year did you quit? _____

4. Do you get short of breath with:

walking?	Yes	No
running?	Yes	No
climbing stairs?	Yes	No
heavy exercise?	Yes	No
just about any activity?	Yes	No

5. Do you have a frequent or chronic cough? Yes No
If so, do you cough up any liquid? Yes No

6. How often do you wheeze? Never Rarely Frequently Constantly

7. Which have you regularly been exposed to: Asbestos? Chemical fumes? Smoke? Coal?

8. Have you been sick or hospitalized in the last three months? Yes No

Please see back of this form.

Please indicate if you have taken any of the following medications in the last year:

<u>Medication</u>	<u>Last taken</u>
Advair	
Alvesco	
Asmanex	
Brovana	
Combivent	
Forodil	
Omnaris	
Proventil (albuterol)	
Pulmicort	
Singulair	
Spiriva	
Symbicort	
Ventolin	
Veramyst	
Xolair	
Xopenex	
Other inhaler: _____	

Thank you for taking the time to answer these questions.