Spirometry Pre-Screening Questionnaire

Name: ________________________________ Height: ________________

Employer: ________________________________ Weight: ________________

DOB: ________________ Today's Date: ________________ Blood Pressure: ________________

QUESTIONS:

• Do you smoke? □ Yes □ No
  If yes, have you smoked within the last hour? □ Yes □ No

• Do you have asthma? □ Yes □ No
  If yes, do you use an inhaler, puffer or bronchodilator □ Yes □ No
  Name of asthma medication? ________________________________
  Frequency of use? ________________________________
  Last time asthma medication was used: ________________________________

• Do you have any respiratory infections/symptoms? □ Yes □ No
  (e.g., coughing, runny nose, flu, bronchitis, coughing up blood, or wheezing)

• Do you have any heart or lung problems? □ Yes □ No

• Recent surgeries? □ Yes □ No
  (e.g., eye, ear, nose, throat, dental, chest/heart, abdominal)
  Date: ________________ Type: ________________________________

• Do you have a history of aneurysm or weakness in one of your major blood vessels? □ Yes □ No

• Have you had caffeine today? □ Yes □ No
  If so, how much? ________________________________

• Do you have a tongue piercing or wear dentures? □ Yes □ No

• Did you eat a large meal in the last 2 hours? □ Yes □ No

• Are you wearing tight clothing or anything that will prevent you from taking a deep breath? □ Yes □ No
  (If so put patient in gown)

• Are you pregnant? Postpone if in last trimester □ Yes □ No

*If the patient has answered ‘Yes’ to any of these questions, please check with the provider prior to proceeding with the pulmonary function test!

**If the patient answered ‘Yes’ please coach on proper positioning