SARATOGA HOSPITAL
MEDICAL GROUP
OCCUPATIONAL MEDICINE
2388 ROUTE 9 • MECHANICVILLE • NY • 12118
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DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

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**