# ALLIANCE HEALTH RESOURCES

**Mobile Division, LTD**

## Pulmonary Function Test Long History Form

Employee:_____ SS #_____ Date:_____

These questions pertain mainly to your chest. Please answer "yes" or "no," if possible. (If you are in doubt about whether the answer is "yes" or "no," record "no.")

### COUGH

1. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) 1. Yes ___ 2. No ___

If yes

A. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week? 1. Yes ___ 2. No ___

B. Do you usually cough at all on getting up, or first thing in the morning? 1. Yes ___ 2. No ___

C. Do you usually cough at all during the rest of the day or at night? 1. Yes ___ 2. No ___

If yes to A, B or C

Do you usually cough like this on most days for 3 consecutive months or more during the year? 1. Yes ___ 2. No ___

For how many years have you had this cough? Number of years _____

### PHLEGM

2.A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) 1. Yes ___ 2. No ___

If yes to 2.A.

B. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week? 1. Yes ___ 2. No ___

C. Do you usually bring up phlegm at all on getting up, or first thing in the morning? 1. Yes ___ 2. No ___

D. Do you usually bring up phlegm at all during the rest of the day or at night? 1. Yes ___ 2. No ___

If Yes to B, C or D

Do you usually bring up phlegm like this on most days for 3 consecutive months or more during the year? 1. Yes ___ 2. No ___

For how many years have you had trouble with phlegm?
Number of years. _____

### EPISODES OF COUGH AND PHLEGM

3. Have you had episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year? 1. Yes ___ 2. No ___

If yes to 3.

A. For how long have you had at least 1 such episode per year?
Number of years. _____

## WHEEZING

4. Does your chest ever sound wheezy or whistling:
   - A. When you have a cold? 1. Yes ___ 2. No ___
   - B. Occasionally apart from colds? 1. Yes ___ 2. No ___

If yes to 4.A. or 4.B.

- C. On most days or nights? 1. Yes ___ 2. No ___
- D. For how many years has this been present? Number of years. _____

5.A. Have you ever had an attack of wheezing that has made you feel short of breath? 1. Yes ___ 2. No ___

If Yes to 5.A.

- B. How old were you when you had your first such attack? Age in years. _____
- C. Have you had 2 or more such episodes? 1. Yes ___ 2. No ___
- D. Have you ever required medicine for the(se) attack(s)? 1. Yes ___ 2. No ___

## SHORTNESS OF BREATH

6. Are you disabled from walking by any condition other than heart or lung disease? 1. Yes ___ 2. No ___

If yes

- A. Please describe below the nature of the(se) conditions.

If yes to 6. skip 7.A.-F.

7.A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? 1. Yes ___ 2. No ___

If Yes to 7.A.

- B. Do you have to walk slower than people of your own age on the level because of breathlessness? 1. Yes ___ 2. No ___
- C. Do you ever have to stop for breath when walking at your own pace on the level? 1. Yes ___ 2. No ___
- D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level? 1. Yes ___ 2. No ___
- E. Are you too breathless to leave the house or breathless on dressing and undressing? 1. Yes ___ 2. No ___
- F. For how long have you been this short of breath? Number of years. _____

## CHEST ILLNESSES

8.A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors, at home, or in bed? 1. Yes ___ 2. No ___

If yes to A.

B. Did you produce phlegm with any of these illnesses? 1. Yes ___ 2. No ___

C. In the last 3 years, how many such illnesses with (increased) phlegm, did you have which lasted a week or more?

Number of illnesses _____

If any "yes" to #2, use "increased." If all "no" to #2, delete "increased."

9. Have you ever had any of the following?

A. Attacks of bronchitis? 1. Yes ___ 2. No ___

If yes to A.

Was it confirmed by a doctor? 1. Yes ___ 2. No ___

At what age was your first attack? _____ Age in years

B. Pneumonia (include bronchopneumonia)? 1. Yes ___ 2. No ___

If yes to B.

Was it confirmed by a doctor? 1. Yes ___ 2. No ___

At what age did you first have it? _____ Age in years

C. Hay fever? 1. Yes ___ 2. No ___

If yes to C.

Was it confirmed by a doctor? 1. Yes ___ 2. No ___

At what age did it start? _____ Age in years

D. Sinus trouble? 1. Yes ___ 2. No ___

If yes to D.

Was it confirmed by a doctor? 1. Yes ___ 2. No ___ 3. Does not apply ___

At what age did it start? _____ Age in years 3. Does not apply ___

E. Pulmonary Tuberculosis? 1. Yes ___ 2. No ___

If yes to E.

Was it confirmed by a doctor? 1. Yes ___ 2. No ___ 3. Does not apply ___

At what age did it start? _____ Age in years 3. Does not apply

10. Have you ever had chronic bronchitis? 1. Yes ___ 2. No ___

If yes to 10

| | |
|---|---|
| Do you still have it? | 1. Yes ___ 2. No ___ |
| Was it confirmed by a doctor? | 1. Yes ___ 2. No ___ |
| At what age did it start? | _____ Age in years |

11. Have you ever had emphysema? 1. Yes ___ 2. No ___

If yes to 11

| | |
|---|---|
| Do you still have it? | 1. Yes ___ 2. No ___ |
| Was it confirmed by a doctor? | 1. Yes ___ 2. No ___ |
| At what age did it start? | _____ Age in years |

12. Have you ever had asthma? 1. Yes ___ 2. No ___

If yes to 12

| | |
|---|---|
| Do you still have it? | 1. Yes ___ 2. No ___ |
| Was it confirmed by a doctor? | 1. Yes ___ 2. No ___ |
| At what age did it start? | _____ Age in years |
| If you no longer have it, at what age did it stop? | _____ Age stopped |
| Do you currently require medicine or treatment for asthma? | 1. Yes ___ 2. No ___ |

**PAST ILLNESSES**

13. Have you ever had? (if Y, please specify)?

A. Any other chest illness? 1. Yes ___ 2. No ___

If yes, please specify

B. Any chest operations? 1. Yes___ 2. No ___

If yes, please specify

C. Any chest injuries? 1. Yes___ 2. No ___

If yes, please specify

## CIGARETTE SMOKING

14.A. Have you ever smoked cigarettes? (NO means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime, or less than 1 cigarette a day for 1 year.) 1. Yes ___ 2. No ___

If no, skip to Question 15.A.

B. Do you now smoke cigarettes? (as of 1 month ago) 1. Yes ___ 2. No ___

If No to 14.C.

C. How old were you when you stopped? _____ Age stopped

D. How old were you when you first started regular cigarette smoking? _____ Age in years

E. How many cigarettes do you smoke per day now? (or how many were you smoking when you quit). (record more than 98 as "99") _____Cigarettes per day

F. On the average, over the entire time you smoked, how many cigarettes did you smoke per day? _____Cigarettes per day

G. Do you or did you inhale the cigarette smoke? _____
0 - not at all
1 - slightly
2 - moderately
3 - deeply

Please answer (0, 1, 2 or 3)

H. Do you or did you smoke filter cigarettes? _____
0 - never
1 - less than + the time
2 - about + the time
3 - more than + the time
4 - always

Please answer (0, 1, 2, 3 or 4)

I. Approximately how long has it been since you smoked? _____ Hours

## PIPE SMOKING

15.A. Have you ever smoked a pipe regularly? (YES means more than 12 oz. of tobacco in a lifetime) 1. Yes ___ 2. No ___

If no, skip to Question 16.A.

B. Do you now smoke a pipe regularly? (as of 1 month ago) 1. Yes ___ 2. No ___

If No to 15.C.

C. How old were you when you stopped? _____ Age stopped

D. How old were you when you started to smoke a pipe regularly? _____ Age in years

E. On the average, over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week? (a standard pack of tobacco contains 1.5 oz.) _____ Oz. per week

F. How much pipe tobacco are you smoking now? _____ Oz. per week

G. Do you or did you inhale the pipe smoke?
0 - not at all 1 - slightly 2 - moderately 3 - deeply
_____
Please answer (0, 1, 2 or 3)

## CIGAR SMOKING

16.A. Have you ever smoked cigars regularly? (YES means more than 1 cigar a week for a year) 1. Yes ___ 2. No ___

If no, questionnaire is complete.

B. Do you now smoke cigars regularly? (as of 1 month ago) 1. Yes ___ 2. No ___

If No to 16.C.

C. How old were you when you stopped? _____ Age stopped

D. How old were you when you started smoking cigars regularly? _____ Age in years

E. On the average, over the entire time you smoked cigars, how many cigars did you smoke per week? _____ Cigars per week

F. How many cigars are you smoking now? _____ Cigars per week

G. Do you or did you inhale the cigar smoke?
0 - not at all 1 - slightly 2 - moderately 3 - deeply
_____
Please answer (0, 1, 2 or 3)