PATIENT QUESTIONNAIRE

Name _____
Email _____
Phone _____
Occupation _____

In the workplace, were you ever exposed to

- ☐ Asbestos
- ☐ Coal or silica dust
- ☐ Moldy hay
- ☐ Grain dust

Allergies

Have you ever had allergy skin prick tests (arm or back)? ◯ Yes ◯ No

If so,
When? _____
Which of the following common "allergens" showed skin test reactions:

☐ House dust

Pollen:
☐ tree ☐ grass ☐ ragweed

Animal dander:
☐ dog ☐ cat ☐ horse ☐ other

☐ Mold

☐ Food. Which one(s)? _____

Were allergy desensitized "shots" recommended? ◯ Yes ◯ No

If so, did you receive them, and for how long? _____

Do you experience symptoms of nasal congestion?

- ☐ Runny nose
- ☐ Nasal stuffiness
- ☐ Difficulty breathing through your nose
- ☐ Post-nasal drip (sensation of mucus moving down the throat and gathering at the base of the neck)

Have you noticed a seasonal pattern to symptoms of:

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheeze
- ☐ Nasal congestion

If so, which seasons or times of year are the most challenging for you:

☐ early spring ☐ late spring ☐ early summer ☐ late summer-fall

Smoking

☐ I have never smoked cigarettes.
- ☐ I have smoked cigars. How many per day and for how long? _____
- ☐ I have smoked a pipe. How often and for how long? _____

☐ I currently smoke cigarettes
How many per day, currently, on average? _____
Have you ever been able to quit for more than 1 month? ◯ Yes ◯ No
If so, when and for how long? _____

☐ I quit smoking at age _____

☐ I began smoking at age _____

From the time I began smoking, to the time I quit (or to the present time, if still smoking), I have smoked ___ package per day, on average.

Respiratory infections

I routinely acquire more than one head cold or chest cold per year ◯ Yes ◯ No
I have been admitted to hospital for pneumonia or severe bronchitis ◯ Yes ◯ No
If so, when? _____

I receive or have received the following vaccinations:

- ☐ Influenza. If so, how often? _____
- ☐ COVID. If so, how many shots have you had? _____
- ☐ Pneumonia shot ("Pneumovax" or "Prevnar" – usually a once or at most twice only vaccination)
- ☐ RSV vaccine (a newer, once only vaccine against the respiratory syncytial virus, an infection that can be transmitted from young children)

Family history

Is there a history in first-degree relatives (parents, siblings, children) of any of the following:

☐ Asthma
If so, which relative? _____

☐ Allergy to environmental factors (house dust, pollen, animal dander, mold)
If so, which relative? _____

☐ COPD or emphysema (smoking-related chronic lung disease)
If so, which relative? _____

☐ Lung cancer
If so, which relative? _____

☐ Pulmonary fibrosis
If so, which relative? _____

Other health conditions

Have you been diagnosed with any of the following:

Heart disease

- ☐ Heart attacks
- ☐ Coronary artery disease requiring stent implantation or bypass surgery
- ☐ Heart valve disease
- ☐ Heart failure

☐ Acid reflux (heartburn, indigestion, abdominal bloating)

Do you take prescription medication for this? ◯ Yes ◯ No

If so, which ones? _____

How often do you experience these symptoms? _____

Do you have difficulty swallowing solid food? ◯ Yes ◯ No

Does food or drink ever "go down the wrong way" into your lungs, causing coughing and choking during meals? ◯ Yes ◯ No

☐ Sleep apnea

Have you had a sleep study? ◯ Yes ◯ No

Do you use CPAP as a treatment for sleep apnea? ◯ Yes ◯ No

☐ Cancer

Which type? _____

What treatment did you receive? _____

Medications

Please list all currently used inhalers here, with number of puffs and frequency during the day.
Please list all other prescription medication here.

Name of medication	**Dose (mg)**	**Frequency** Once daily 2 x 3 x 4 x

Pharmacy information

Name of pharmacy _____
Address or street name _____
Drug plan:

- ☐ Ontario drug benefits (seniors' plan for 65 and over)
- ☐ Trillium plan (usually associated with Ontario Disability Supports Program, CPP Disability, and Ontario Works)
- ☐ Employer-funded drug benefits
- ☐ Post-retirement employer-funded drug benefits