LUNG HEALTH QUESTIONNAIRE

MRU02288 (09/21/15)

PLACE PATIENT LABEL TO COVER OR COMPLETE BELOW:

Patient Name:____________________

DOB:__________ Age:________ Sex:________

Account #:____________________

Med Rec #:____________________

PATIENT INFORMATION

Last Name:____________________ First Name:____________________ Middle Initial:______

Date of Birth:__________ Age:______ Sex: ❑ Male ❑ Female

Address:____________________ City:____________________ State:______ Zip:______

Home #:____________________ Cell #:____________________ Other #:____________________

QUESTIONNAIRE

1. Have you ever smoked? ❑ Yes ❑ No → *If no, please skip to question #10.*
2. Choose ONE of the following:
   - ❑ I was ______ years old when I started smoking regularly.
   - ❑ I am only an occasional smoker and I started when I was ______ years old.
3. Do you currently smoke? ❑ Yes ❑ No
4. If you do not currently smoke, how old were you when you stopped? ______ years old ❑ N/A – I still smoke
5. On average, when you smoke(d) how many cigarettes do / did you smoke each day? ______ / day
6. Which brand(s) do / did you smoke? ____________________
7. Approximately how many times have you tried to quit smoking?
   ❑ Never ❑ 1 time ❑ 2 times ❑ 3-4 times ❑ 5 or more times
8. If you have tried to quit smoking, what methods have you used? Check all that apply.
   ❑ Quit on my own ❑ Quit with a relative/friend ❑ Gradually decreased number used ❑ Psychiatrist / Psychologist
   ❑ Nicotine patch ❑ Free stop smoking program ❑ Used low tar / low nicotine cigarettes ❑ Hypnosis / Acupuncture
   ❑ Nicorette gum ❑ Paid stop smoking program ❑ Substituted other tobacco products
   ❑ Zyban ❑ Used special filters / holders ❑ Other (specify):____________________
   Additional information:____________________
9. What was the longest amount of time that you were able to stop smoking (in total)? ____________________
10. Have you had a chest x-ray / CT scan within the last year? ❑ Yes ❑ No
11. Mark each of the following medical conditions that a doctor has said you either have now or have had in the past.
    ❑ Heart attack ❑ Heart failure ❑ Kidney failure ❑ Liver disease ❑ Cancer ❑ Seizures ❑ Bleeding problems
12. Are you aware of a family history of cancer? ❑ Yes ❑ No
    ↳ If yes, please specify:____________________
13. Family Doctor's Name:____________________ Phone #:__________
    Doctor's Mailing Address:____________________ Fax #:__________
14. Are you aware of breathing any harmful substances at work? ❑ Yes ❑ No → If Yes, specify:__________
15. Please tell us how you heard about us by marking ONE of the following choices:
    ❑ Website ❑ Radio ❑ Newspaper ❑ Hospital ❑ Primary Care referral
    ❑ TV ❑ Magazine ❑ Yellow Pages ❑ Employer ❑ Word of Mouth (Family, Friend, etc.)
    ❑ Other (specify):____________________
16. Ethnicity (choose one): ❑ Caucasian ❑ Hispanic ❑ African American ❑ Asian ❑ Other (specify):__________

Time:________ Date:________ Patient or Parent / Guardian Signature:____________________