PATIENT QUESTIONNAIRE

1. **Are you using inhalers?** **Y** **N**

List inhalers and last time used 1.________ 2.________ 3.________
4.________ 5.________ 6.________

2. **Are you smoking?** **Y** **N**

Do you want to quit? Y N

3. **Have you ever had any of the following?** **Please specify date and type if "yes"**

Heart problems?	Y	N	________
Uncontrolled high blood pressure?	Y	N	________
Tuberculosis?	Y	N	________
Coughing up blood?	Y	N	________
Recent Surgery – chest, abdomen, eye?	Y	N	________
Chest injury?	Y	N	________
Pneumonia or pleurisy?	Y	N	________
Recent pneumothorax?	Y	N	________
Recent stroke?	Y	N	________
Known aneurysm – head or abdomen?	Y	N	________
Stress Incontinence	Y	N	________
Recent ear infection, cold, flu	Y	N	________

4. **Have you done any of the following prior to attending this test?**

Strenuous exercise within 30 min.	Y	N
Drank alcohol within 4 hours	Y	N
Ate large meal within 2 hours	Y	N
Had a coffee/caffeinated drink today	Y	N

5. **Have you ever had a breathing test before?** **Y** **N**

NAME: **date:**