Respiratory Medicine

Outpatient Questionnaire

Date: …….. Age ……..

1) What are your main symptoms? (please tick the relevant boxes)

Cough	☐	Chest Tightness	☐
Wheeze	☐	Sleepiness	☐
Chest Pain	☐	Coughing up blood	☐
Breathlessness	☐	Hoarseness	☐
Weight loss	☐	Other	☐

If you have ticked other, please give further details

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2) How long have you been having these symptoms?

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3) How far can you walk on the flat before breathlessness stops you?

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4) Have you ever smoked? Yes ☐ No ☐

Start age: ……. Stop age: ……. Number per day: …….

5) On average how many units of alcohol do you drink per week? ……..
(1 unit = 1 glass of wine, half a pint of beer, 1 “pub” measure of spirits)

6) Are you allergic to any medicines? Yes ☐ No ☐

If you have ticked yes, please list what medicines and what happens.

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7) Are you allergic to cats/dogs/dust or have hayfever or eczema?

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8) Have you had any exposure to asbestos? Yes ☐ No ☐

9) Please list your main occupation(s) starting with the most recent (and include dates)

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10) Do you have contact with any pets (including birds) either your own or someone else’s?

Yes ☐ No ☐

If you have ticked yes, please give further details

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11) Is there any history in your family (not your partner's) of lung disease such as asthma, emphysema, blood clots on the lung, cystic fibrosis?

Yes ☐ No ☐

If you have ticked yes, please give further details

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12) Is there a family history of any other significant diseases, eg heart attacks, strokes, cancers?

Yes ☐ No ☐

If you have ticked yes, please give further details

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13) Please list any serious illnesses, hospital admissions or operations (include removal of skin moles, high blood pressure, blood clots on the lung or in the legs, tuberculosis, diabetes, heart problems, strokes or kidney problems). Please include dates.

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14) Please either list all tablets you are currently taking with strengths and doses or attach a GP print out. Please list your inhalers and the exact dose of your preventative (brown) inhaler

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