Name:_____ Age: ___ Sex: F M Date: _____

A. Why did your doctor refere you? □ You don't know
-or- what problem or problems do you want us to assess? □ You don't have any problems

How long have you had this problem? □ You don't know

B. Tell us about your medical history:

1. Have you ever been diagnosed with a lung problem? □ No □ Yes
   Please check all that applies:
   □ Asthma □ Emphysema/bronchitis/COPD □ Other (explain):_____
2. Do you have any of the following chronic illnesses? □ No □ Yes
   - □ High blood pressure
   - □ Diabetes
   - □ High cholesterol
   - □ Heart disease
   - □ Stomach problems (reflux, heartburn, ulcer)
   - □ Sinus problems
3. Any other chronic illnesses? □ No □ Yes (please list)
4. Have you ever had an operation or surgery? □ No □ Yes: Approximately when? What was done?

Turn the page please ---->

C. Do you have any allergies? □ No □ Yes: Please list any drug allergies you have **and** the **reaction** to it.

Please check off any other allergies you have:
□animals □pollens □dust/dustmite □food

D. List all your medications (including inhalers, patches, injection, herbal or natural remedies orsupplements). You can use the next page if necessary or attach a list.

_____ Dose: ___ mg __ times/day	_____Dose: ___ mg __ times/day
_____ Dose: ___ mg __ times/day	_____ Dose: ___ mg __ times/day
_____ Dose: ___ mg __ times/day	_____ Dose: ___ mg __ times/day
_____ Dose: ___ mg __ times/day	_____ Dose: ___ mg __ times/day
_____ Dose: ___ mg __ times/day	_____ Dose: ___ mg __ times/day

E. Did you ever smoke?
- □ No ... Skip to the section F
- □ Yes: You first started at age: ___
  You usually smoke(d) about ___ cigarettes/day or ___ cigars/day
  □ You quit smoking at age ___ (how many years ago? ___)
  -or-
  □ You still smoke.

F. Do you drink any alcohol currently?
- □ None at all
- □ only a few times /year
- □ Yes: How much do you drink over a typical week including weekends (add it up):
  ___ bottles of beer ___ oz. of liquor ____ glasses of wine ____bottles of wine

G. Do you currently use:
Marijuana ..... □ No □ Yes
Cocaine ..... □ No □ Yes
Other street drugs .... □ No □ Yes

H. Family Medical History:

What serious illnesses run in the family?

- You mother is □alive .... her age: ___ serious illnesses during her life:_____
  □dead .... age at death: ___ cause of death:_____
- You father is □alive .... his age: ___ serious illnesses during his life:_____
  □dead .... age at death: ___ cause of death:_____
- You have:
  - ____ sisters. How many alive? ____ , any serious illnesses? _____
  - ____ brothers. How many alive? ____ , any serious illnesses? _____
  - ____ daughters. How many alive? ____ , any serious illnesses? _____
  - ____ sons. How many alive? ____ , any serious illnesses? _____

Name:

I. Work History:

- Are you currently working outside of home?
  - □ Yes .... what do you do?
  - □ No ....□ You are a homemaker
    - □ You are unemployed
    - □ You are on disability since _____ bacuase of _____
    - □ Retired since ____
- Have you ever worked in:

  □ mine □mill □factory □farm □ barn □construction/renovation

  When approximately? ____ How long? ____

  What was your job title? (please list all)

K. Other exposures:

Do you have any pets (including birds) currently?

□Yes: (please list) _____

□No: Have you ever had pets? □ No □ Yes (please list) _____

Thank you.

Parisa Rahimi, MD FRCPC