

E.N.T. Voice & Sinus Center of Nevada  
 Dr. Susan Schwartz  
 EVALUATION PRIOR TO PULMONARY FUNCTION TEST

<b>Check off any lung or breathing problems or symptoms</b>		
<input type="checkbox"/> Unable to catch your breath		
<input type="checkbox"/> Wheezing		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Heart Murmur		
<input type="checkbox"/> Unable to sleep laying flat or with One(1) pillow		
<input type="checkbox"/> Sudden onset of difficulty breathing		
<input type="checkbox"/> Night sweats		
<input type="checkbox"/> Fainting		
<input type="checkbox"/> Chest Pains or Pressure		
<input type="checkbox"/> Shortness of Breath		
<input type="checkbox"/> Dizziness		
<input type="checkbox"/> Swollen Legs		
<input type="checkbox"/> Heart Failure		
<input type="checkbox"/> Blue Lips or Fingernails		
<input type="checkbox"/> Leg Cramps when you walk		
<b>Have you ever had:</b>		
<input type="checkbox"/> A Pulmonary Stress Test		
<input type="checkbox"/> An Electrocardiogram		
<input type="checkbox"/> A Pulmonary Function or Spirometry Test		
<input type="checkbox"/> A Bronchoscopy or Bronchial/Lung Biopsy		
<input type="checkbox"/> Lung Surgery, including complete or partial removal of lung		
<input type="checkbox"/> Heart Surgery		
<input type="checkbox"/> Lung Cancer		
<input type="checkbox"/> Exposure to Tuberculosis or Had Tuberculosis		
<b>Tell us about your risk of lung disease</b>		
<b>Please check if you have:</b>		
<input type="checkbox"/> Worked around toxic chemicals or substances		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Ever Smoked		
<input type="checkbox"/> Lived with someone who smokes		
<input type="checkbox"/> Do you exercise (including walking) _____		
<input type="checkbox"/> Has a close family member had lung cancer, tuberculosis, or emphysema? _____		
<input type="checkbox"/> WHO? _____		
<input type="checkbox"/> If you are a female, have you passed menopause? _____		
<input type="checkbox"/> If yes, what age? _____		
<input type="checkbox"/> Do you take estrogen replacement? _____		
<input type="checkbox"/> Please tell us anything else about your lungs: _____		
_____		