

## Interstitial and Diffuse Lung Disease Patient Questionnaire

**1. How often do you cough?** *(Do not include clearing your throat.)*

- Not at all or rarely  
 Occasionally, but not bothersome  
 Most days  
 Often or in severe attacks that interfere with activity

**2. How long have you been coughing?** \_\_\_\_\_ *(indicate in months, years)*

**3. Do you cough at night?** Yes \_\_\_\_\_ No \_\_\_\_\_

*If you cough at night, does it awaken you?* Yes \_\_\_\_\_ No \_\_\_\_\_

**4. The cough produces (check all that apply):**

No phlegm  Phlegm  Blood  I don't cough

**5. Check the single number that describes the point at which you become short of breath:**

0. I am not troubled with breathlessness except with strenuous exercise.  
 1. I get short of breath when hurrying on level ground or walking up a slight hill.  
 2. On level ground, I walk slower than people my age because of breathlessness or I have to stop for breath when walking on my own pace.  
 4. I stop for breath after walking about 100 yards (90 meters) (or after a few minutes) on level ground.  
 5. I am too breathless to leave the house or breathless while dressing or undressing.

**6. When did your shortness of breath begin?** \_\_\_\_\_

**7. Has a doctor ever told you that you have:**

**Have you noticed any symptoms:**

	YES	NO		YES	NO
Heart disease	_____	_____	Weight loss	_____	_____
Thyroid disease	_____	_____	Difficulty swallowing	_____	_____
Diabetes	_____	_____	Heartburn or reflux	_____	_____
Sinus disease	_____	_____	Dry eyes or dry mouth	_____	_____
Stroke	_____	_____	Rash or change in skin	_____	_____
Seizure	_____	_____	Foot or leg swelling	_____	_____
Eye inflammation	_____	_____	Sensitivity to light	_____	_____
Mononucleosis	_____	_____	Bruising	_____	_____
Hepatitis B or C	_____	_____	Hand ulcers	_____	_____
Tuberculosis	_____	_____	Mouth ulcers	_____	_____
Kidney disease	_____	_____	Chest pain	_____	_____
Kidney stones	_____	_____	Joint pain or swelling	_____	_____
Blood in urine	_____	_____			
Pleurisy	_____	_____			
Pneumonia	_____	_____			
Asthma	_____	_____			
Blood clots	_____	_____			
Pulmonary hypertension	_____	_____			
Heart failure	_____	_____			
("Fluid on the lungs")	_____	_____			

**8. Have you ever smoked, inhaled, or injected "recreational" drugs?** Yes \_\_\_\_\_ No \_\_\_\_\_  
*(Include "street drugs" or crushed pills. Do not include prescribed inhalers.)*

**9. Have you smoked 5 packs of cigarettes or more in your life?** Yes \_\_\_\_\_ No \_\_\_\_\_  
**If yes,**  
 Do you smoke now? \_\_\_\_\_  
 How old were you when you started? \_\_\_\_\_ years old  
 Average number of cigarettes per day \_\_\_\_\_ cigarettes  
**If you quit,**  
 How old were you when you quit? \_\_\_\_\_ years old

**10. Do any of your children, parents, grandparents, siblings, aunts, uncles, or cousins have any of the following lung diseases?** Yes \_\_\_\_\_ No \_\_\_\_\_

Emphysema, Chronic Obstructive Pulmonary Disease (COPD)	_____	_____		_____	_____
Asthma	_____			_____	_____
Sarcoidosis	_____			_____	_____
Cystic fibrosis	_____			_____	_____
Pulmonary fibrosis	_____			_____	_____
Hypersensitivity pneumonitis	_____			_____	_____

**11. Have you lived in an old house within the past 10 years?** Yes \_\_\_\_\_ No \_\_\_\_\_

**12. Does your current or past home or work place have any of the following?**

	Yes	No		Yes	No
Humidifier	_____	_____	Water damage	_____	_____
Sauna	_____	_____	Mold	_____	_____
Hot tub/Jacuzzi	_____	_____	Animals	_____	_____
Birds <i>(Include pigeons, doves, parakeets, cockatiels, chickens, ducks, geese, pheasants)</i>	_____	_____			

**13. Have you ever had a chest X-ray or CT scan of the chest?**  
*If yes, please indicate the earliest and most recent you can remember:*  
 Earliest X-ray: Year \_\_\_\_ Where? \_\_\_\_\_ Most recent X-ray: Year \_\_\_\_ Where? \_\_\_\_\_  
 Earliest CT scan: Year \_\_\_\_ Where? \_\_\_\_\_ Most recent CT scan: Year \_\_\_\_ Where? \_\_\_\_\_

**14. Where have you previously lived?** *(List all locations where you lived for at least 6 months.)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Outside this country?** *(Indicate which countries.)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes No

15. Have you lived or worked in environment where you were exposed to heavy smoke or dust? \_\_\_\_\_

16. Occupational history (include all occupations you've had):

Occupation	Years worked	Exposures (Dust, metal, paint, fine particles, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

17. Have you performed any of the following occupations?

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Farm work    | <input type="checkbox"/> Automotive mechanic | <input type="checkbox"/> Carpenter         |
| <input type="checkbox"/> Painter      | <input type="checkbox"/> Welder              | <input type="checkbox"/> Laboratory worker |
| <input type="checkbox"/> Sand blaster | <input type="checkbox"/> Insulator           | <input type="checkbox"/> Longshoreman      |
| <input type="checkbox"/> Pipe fitter  | <input type="checkbox"/> Vineyard worker     |  |

18. Have you worked in any of the following locations:

- |  |  |
|--|--|
| <input type="checkbox"/> Mine            | <input type="checkbox"/> Foundry             |
| <input type="checkbox"/> Quarry          | <input type="checkbox"/> Railroad            |
| <input type="checkbox"/> Pulp mill       | <input type="checkbox"/> Paper mill          |
| <input type="checkbox"/> Bakery          | <input type="checkbox"/> Smelting            |
| <input type="checkbox"/> Plastic factory | <input type="checkbox"/> Tunnel construction |

19. Have you ever been exposed to the following at work/ home/ elsewhere?

Animals and farming	Metals/rocks	Food/plant Production	Miscellaneous	Skilled
Birds	Beryllium	Cheese	Cotton	Cork
Feathers	Cobalt	Maple Bark	Wood	Detergent (isocyanates)
Fishmeal	Tin	Wheat	Industrial strength cleaning solution	Pottery
Insecticide	Iron oxide	Coffee/ tea	Oily Nosedrops	Talc
Fertilizer	Aluminum	Mushroom		Paint
	Mica	Oil		Cement
	Silica	Sugar cane		Pipes
	Asbestos	Malt		Brakes
	Coal	Meat		Tile (ceramic)

20. List any other unusual exposures that you feel might be important to note.

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**21. Have you had any of the following medical problems?**

- Pneumothorax (*collapsed lung*)
- Bleeding disorder
- Vasculitis (*inflammation of the blood vessels*)
- Raynaud's phenomenon (*fingers painful and turning colors on cold exposure*)
- Rheumatologic disease (*This includes rheumatoid arthritis, lupus, scleroderma, mixed connective tissue disease, Sjogren's syndrome, Wegener's, polymyositis or dermatomyositis, Bechet's disease, ankylosing spondylitis.*)
- Bowel disease (*This includes Crohn's disease, ulcerative colitis, primary biliary cirrhosis, celiac or Whipple's disease.*)

**22. Have you ever taken any of the following medications?**

**Anti-inflammatory medications:**

- Azathiapriner (Imuran)
- Chlorambucil
- Colchicine
- Gold salts
- Interferon (any)
- Methotrexate
- Penicillamine
- Prednisone

**Cancer therapy:**

- Busulfan
- Bleomycin
- Cyclophosphamide
- Etoposide
- GMCSF
- Mitomycin
- Nilutamide
- Nitrosoureas
- Radiation
- Vinblastine

**Miscellaneous medications:**

- Fenfluramine/ dexfenfluramine
- Leukotriene inhibitor (Singulair, Accolate)
- Propylthiouracil
- Bladder BCG

**Antibiotics/infection treatment:**

- Cephalosporin
- Isoniazid (INH)
- Macrolide
- Minocycline
- Nitrofurantoin (Macrochantin)
- Penicillin
- Sulfonamides (TMP-SMX)

**Cardiovascular medications:**

- Amiodarone (Cordarone)
- Captopril (Capoten)
- Hydralazine
- Hydrochlorothiazide
- Procainamide (Procain SR)
- Sotalol

**Gastrointestinal medications:**

- Azulfidine
- Sulfasalazine

**Neurological medications:**

- Bromocriptine
- Carbamazepine (Tegretol)
- L tryptophan
- Phenytoin (Dilantin)

**Disclaimer**

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