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?  
(Include “street drugs” or crushed pills. Do not include prescribed inhalers.)

   Yes  No

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?  
   Average number of cigarettes per day  

   If you quit,
   How old were you when you quit?  

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  

   Yes    No

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
   Humidifier  
   Sauna  
   Hot tub/Jacuzzi  
   Birds (Include pigeons, doves, parakeets, cockatiels, chickens, ducks, geese, pheasants)  
   Water damage  
   Mold  
   Animals  

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 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.)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
15. Have you lived or worked in environment where you were exposed to heavy smoke or dust?  
   Yes  No

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

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Years worked</th>
<th>Exposures (Dust, metal, paint, fine particles, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

17. Have you performed any of the following occupations?

   ____ Farm work  ____ Automotive mechanic  ____ Carpenter
   ____ Painter    ____ Welder                  ____ Laboratory worker
   ____ Sand blaster ____ Insulator            ____ Longshoreman
   ____ Pipe fitter  ____ Insulator            ____ Longshoreman

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

   ____ Mine   ____ Foundry
   ____ Quarry  ____ Railroad
   ____ Pulp mill  ____ Paper mill
   ____ Bakery  ____ Smelting
   ____ Plastic factory  ____ Tunnel construction

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

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

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

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
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:**
- Azathiaprine (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 (Singulaire, Accolate)
- Propylthiouracil
- Bladder BCG

**Antibiotics/infection treatment:**
- Cephalosporin
- Isoniazid (INH)
- Macrolide
- Minocycline
- Nitrofurantoin (Macrodantin)
- Penicillin
- Sulfonamides (TMP-SMX)

**Cancer therapy:**
- Amiodarone (Cordarone)
- Captopril (Capoten)
- Hydralazine
- Hydrochlorothiazide
- Procainamide (Procain SR)
- Sotolol

**Gastrointestinal medications:**
- Azulfidine
- Sulfasalazine

**Neurological medications:**
- Bromocriptine
- Carbemazepine (Tegretol)
- L tryptophan
- Phenytoin (Dilantin)

**Cardiovascular medications:**
- Amiodarone (Cordarone)
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