

RESPIRATORY QUESTIONNAIRE

Please fax back to IPA at 781 643-2775

Name: _____ DOB: _____

1. Have you ever suffered from any of the following, if so, please indicate and date last time the event happened?
 - a. Bronchitis _____
 - b. Asthma _____
 - c. Emphysema _____
 - d. Chronic cough _____
 - e. Pneumonia _____
 - f. Other (explain) _____
2. Date of first attack _____
3. Date of last attack _____
4. How often do your attacks occur and last? _____
5. How would you rate your attacks (please circle below)?
Mild Moderate Severe Coughing of blood Coughing of phlegm
6. Have you ever lost any time from work? _____
7. If yes, how long and why? _____
8. Have you ever been hospitalized or had to go to emergency room? _____

9. What was the diagnosis for the above? _____

10. Are you under any treatment currently, if so, what is the treatment or medication, how often do you have to take it? _____

11. What is the name of your physician? _____

12. Do you experience any shortness of breath? _____

13. Do you have any wheezing or any other type of respiratory/lung problems? _____

14. Do you experience any problems with stair climbing or exercise? _____

15. Do you smoke or use any other form of tobacco? _____

Agent Name: _____

Phone Number: _____ Fax No: _____

Date: _____ E-mail Address: _____

Please circle the associate you work with. Russ, Rhonda, Leo