CHEST™

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:**

	YES	NO
Heart disease	____	____
Thyroid disease	____	____
Diabetes	____	____
Sinus disease	____	____
Stroke	____	____
Seizure	____	____
Eye inflammation	____	____
Mononucleosis	____	____
Hepatitis B or C	____	____
Tuberculosis	____	____
Kidney disease	____	____
Kidney stones	____	____
Blood in urine	____	____
Pleurisy	____	____
Pneumonia	____	____
Asthma	____	____
Blood clots	____	____
Pulmonary hypertension	____	____
Heart failure ("Fluid on the lungs")	____	____

Have you noticed any symptoms:

	YES	NO
Weight loss	____	____
Difficulty swallowing	____	____
Heartburn or reflux	____	____
Dry eyes or dry mouth	____	____
Rash or change in skin	____	____
Foot or leg swelling	____	____
Sensitivity to light	____	____
Bruising	____	____
Hand ulcers	____	____
Mouth ulcers	____	____
Chest pain	____	____
Joint pain or swelling	____	____

	Yes	No
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?	_____	_____
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	_____	_____

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

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 *(Include pigeons, doves, parakeets, cockatiels, chickens, ducks, geese, pheasants)*	_____	_____			

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?

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

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?

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.

_____

_____

_____

_____

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 treament:

_____Cephalosporin

_____Isoniazid (INH)

_____Macrolide

_____Minocycline

_____Nitrofurantoin (Macrodantin)

_____Penicillin

_____Sulfonamides (TMP-SMX)

Cardiovascular medications:

_____Amiodarone (Cordarone)

_____Captopril (Capoten)

_____Hydralazine

_____Hydrochlorothiazide

_____Procainamide (Procain SR)

_____Sotolol

Gastrointestinal medications:

_____Azulfidine

_____Sulfasalazine

Neurological medications:

_____Bromocriptine

_____Carbemazepine (Tegretol)

_____L tryptophan

_____Phenytoin (Dilantin)