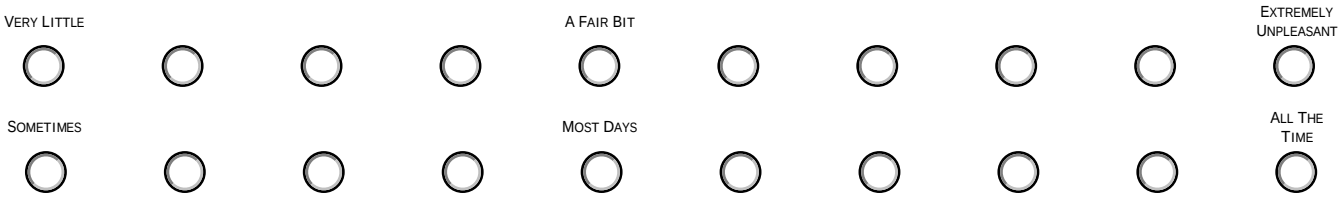
ALL ABOUT YOUR BREATHING

1. How long has your breathing been a problem?

   _____

2. How much does it trouble you? *(Please circle)*



3. Do you have:

	Yes	No
a. Cough or sputum?	☐	☐
b. Recurrent chest infections or bronchitis?	☐	☐
c. Chest pain or tightness?	☐	☐
d. Palpitations?	☐	☐
e. Wheezing (noisy breathing)?	☐	☐
f. Hayfever?	☐	☐
g. Family history of asthma?	☐	☐
h. Fevers or frequent sweats?	☐	☐
i. Recent weight loss?	☐	☐
j. Coughing up blood?	☐	☐
k. Swelling in your legs?	☐	☐
l. Indigestion or reflux?	☐	☐
m. Anxiety or panic attacks?	☐	☐
n. Feelings of depression?	☐	☐
o. Fatigue or tiredness?	☐	☐

4. Are your symptoms worse at a particular time of day or season?

   _____

5. Are your symptoms triggered by certain things (i.e. pollens, dusts, changes in climate, exercise, fumes, animals etc.)?

   _____

6. Are your symptoms worse when lying flat?

   _____

7. How far can you walk on a level ground before having to stop?

   _____

8. Have you every smoked? Yes ☐ No ☐

   If yes:

   Age started?_____ Age stopped?_____ How many a day?_____

   If no:

   Do you/did you live with anyone who smoked? _____

9. Do you keep or have you kept any pets? _____

ALL ABOUT YOUR BREATHING

Occupational history, including any major chemicals or dust exposure:

YEAR COMMENCED AND FINISHED	JOB DESCRIPTION	COMPANY

Please list all **medical conditions** you have?

_____

_____

_____

Please list your current **medications**:

MEDICATION	DOSE	HOW MANY TIMES A DAY	MEDICATION	DOSE	HOW MANY TIMES A DAY

Do you have any **allergies**? Yes ☐ No ☐

If yes please list (including food, drugs, lotions, latex):

_____

_____