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?  
If yes,  
Do you smoke now?  
How old were you when you started?  
Average number of cigarettes per day

Yes  No

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

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  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 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?  
____  ______

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>
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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  ____ 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?

<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>
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<td>Feathers</td>
<td>Cobalt</td>
<td>Maple Bark</td>
<td>Wood</td>
<td>Detergent (isocyanates)</td>
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<td>Fishmeal</td>
<td>Tin</td>
<td>Wheat</td>
<td>Industrial strength cleaning solution</td>
<td>Pottery</td>
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<td>Iron oxide</td>
<td>Coffee/ tea</td>
<td>Oily Nosedrops</td>
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<td>Sugar cane</td>
<td>Pipes</td>
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<tr>
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<td>Malt</td>
<td>Brakes</td>
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<td>Coal</td>
<td>Meat</td>
<td>Tile (ceramic)</td>
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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:**
   ___ Azathiaprine (Imuran)
   ___ Chlorambucil
   ___ Colchicine
   ___ Gold salts
   ___ Interferon (any)
   ___ Methotrexate
   ___ Penicillamine
   ___ Prednisone

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

   **Cancer therapy:**
   ___ Busulfan
   ___ Bleomycin
   ___ Cyclophosphamide
   ___ Etoposide
   ___ GMCSF
   ___ Mitomycin
   ___ Nitramide
   ___ Nitrosoacids
   ___ Radiation
   ___ Vinblastine

   **Cardiovascular medications:**
   ___ Amiodarone (Cordarone)
   ___ Captopril (Capoten)
   ___ Hydralazine
   ___ Hydrochlorothiazide
   ___ Procainamide (Procin SR)
   ___ Sotolol

   **Gastrointestinal medications:**
   ___ Azulfidine
   ___ Sulfasalazine

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

   **Miscellaneous medications:**
   ___ Fenfluramine/ dexfenfluramine
   ___ Leukotriene inhibitor (Singulaire, Accolate)
   ___ Propylthiouracil
   ___ Bladder BCG

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**Disclaimer**

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