



ILD Patient Questionnaire



Your Health

1. How often do you cough?

(Do not include clearing your throat.)

Not at all, or only rarely

Occasionally

Most days

Often or in severe attacks that interfere with activities

2. How long have you been coughing?

___ Months

___ Years

___ Not Applicable

3. The cough produces: (check all that apply)

No phlegm

Phlegm

Blood

don't cough



4. Choose one that best describes when you become short of breath.

I am not troubled with breathlessness except during strenuous exercise.

I get short of breath when hurrying on level ground or walking up a slight hill

I stop for breath after walking about 100 yards (90 meters) or after a few minutes.

I am too breathless to leave the house or get breathless when dressing or undressing.

I walk slower than other people my age because of breathlessness, or I have to stop to breathe when walking at my own pace.

5. Has a doctor ever told you that you have:

YES NO

Asthma

Blood clots

Blood in urine

Diabetes

Eye inflammation

Fluid on the lungs

Heart disease

Heart failure

Hepatitis B or C

Kidney disease

Kidney stones

Mononucleosis

Pleurisy

Pneumonia

YES NO

Pulmonary

hypertension

Seizure

Sinus disease

Stroke

Thyroid disease

Tuberculosis

YES NO

6. Have you been diagnosed with any of these conditions?

Bleeding disorder

Bowel disease (includes Crohn's disease, ulcerative colitis, primary biliary cirrhosis, celiac, or Whipple's disease)

Raynaud's phenomenon (fingers painful and turning colors on cold exposure)

Rheumatologic disease (includes rheumatoid arthritis, lupus, scleroderma, mixed connective tissue disease, Sjogren's syndrome, granulomatosis with polyangiitis [Wegener's], polymyositis or dermatomyositis, Behçet disease, ankylosing spondylitis)

Vasculitis (inflammation of blood vessels)

Collapsed lung (pneumothorax)

7. Have you ever had a chest x-ray or computed tomography (CT) scan of your chest?

YES

NO



8. Have you noticed any of these symptoms?

YES NO

- Bruising
- Chest pain
- Difficulty swallowing
- Dry eyes or dry mouth
- Foot or leg swelling
- Hand ulcers

YES NO

- Heartburn or reflux
- Joint pain or swelling
- Mouth ulcers
- Rash or change in skin
- Sensitivity to light
- Weight loss

9a. Have you smoked 100 cigarettes (5 packs) or more in your life?

YES

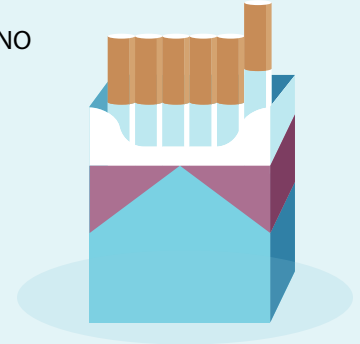
NO

If yes, do you smoke now? YES NO

How old were you when you started smoking? _____

If you quit, how old were you when you quit? _____

9b. Average number of cigarettes per day: _____



Travel



10. Where have you traveled in the past 5 years?

11. Have you lived outside the country? If so, where?

Family History

12. Does anyone in your family have a history of the following?

- | | |
|--|---|
| Asthma | Sarcoidosis |
| Chronic obstructive pulmonary disease (COPD) | Scarring of the liver (cirrhosis) |
| Cystic fibrosis | Trouble making healthy blood cells (myelodysplastic syndrome) |
| Hypersensitivity pneumonitis | Unexplained low red blood cell count (anemia) |
| Pulmonary fibrosis | |



13. Did anyone in your family have their hair go gray early (in their teens or early twenties)?

YES

NO

Medications

Bring a list of medications you're taking or have taken in the past to your appointment.

14. Have you ever taken any of these medications?

Anti-inflammatory Medications

Interferon (*any variety*)

Methotrexate

Prednisone

Other: _____

Cancer Therapies

Busulfan (*Myleran*)

Cyclophosphamide

Radiation

Other: _____

Antibiotics/Infection Treatment

Cephalosporin

Penicillin

Other: _____

Cardiovascular

Hydrochlorothiazide (*Ziac*)

Sotalol (*Betapace*)

Other: _____

Neurological

Bromocriptine

Carbamazepine (*Tegretol*)

Other: _____

Gastrointestinal

Sulfasalazine (*Azulfidine*)

Other: _____

Miscellaneous

Bladder bacillus Calmette-Guerin (BCG)

Fenfluramine/dexfenfluramine

Other: _____

Home and Work

15a. Does your current or past home have any of the following?

Hot tub/Jacuzzi

Humidifier

Mold

Sauna

Water damage

15b. What pets do you have?

Cats

Dogs

Other

Birds (*includes pigeons, doves, parakeets, cockatiels, chickens, ducks, geese, pheasants*)

16. Have you been worried about anything you were exposed to at a job?

17. List all of your current and past jobs:

Job

Years Worked

18. Have you ever had any of these jobs?

Automotive mechanic

Carpenter

Farm worker

Insulator

Laboratory worker

Longshoreman

Painter

Pipe fitter

Sand blaster

Vineyard worker

Welder





19. Have you ever worked in any of the following locations?

- | | |
|-----------------|--------------------------|
| Bakery | Pulp mill |
| Foundry | Quarry |
| Mine | Railroad |
| Paper mill | Smelting facility |
| Plastic factory | Tunnel construction site |

20. Have you ever been exposed to the following at work, home, or somewhere else?

Animals & Farming	YES	NO	Metal/Rocks	YES	NO	Metal/Rocks	YES	NO
Birds			Aluminum			Cobalt		
Feathers			Asbestos (<i>powdered or in the air</i>)			Iron oxide		
Fertilizer			Beryllium			Mica		
Fishmeal			Coal			Tin		
Insecticide						Silica		
Food/Plant Production	YES	NO	Miscellaneous	YES	NO	Skilled	YES	NO
Bark			Cotton			Brakes		
Cheese			Down or feathers (<i>in pillows, comforters, cushions, or jackets</i>)			Cement		
Coffee/tea			Industrial-strength cleaning solution			Detergent (<i>isocyanates</i>)		
Maple			Oily nose drops			Paint		
Malt			Water damage in your house or basement			Pipes		
Meat			Wood			Pottery		
Mushrooms						Talc		
Oil						Tile (<i>ceramic</i>)		
Sugar cane								
Wheat								

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