CHEST Interstitial and Diffuse Lung Disease Patient Questionnaire

1. **How often do you cough?** *(Do not include clearing your throat.)*
   - [ ] Not at all, or only rarely
   - [ ] Occasionally, but not bothersome
   - [ ] Most days
   - [ ] Often or in severe attacks that interfere with activity

2. **How long have you been coughing?**
   - ___ Months
   - ___ Years
   - ___ Not applicable

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
   - [ ] Don’t cough

5. **Check the single number that describes the point at which you become short of breath:**
   - [ ] 1. I am not troubled with breathlessness except with strenuous exercise.
   - [ ] 2. I get short of breath when hurrying on level ground or walking up a slight hill.
   - [ ] 3. I walk slower than people of my age because of breathlessness or I have to stop from breath when walking on my own pace.
   - [ ] 4. I stop for breath after walking about 100 yards (90 meters) (or after a few minutes).
   - [ ] 5. I am too breathless to leave the house or breathless on dressing or undressing.

6. **When did your shortness of breath begin?**

7. **Has a doctor ever told you that you have:**

<table>
<thead>
<tr>
<th>Disease</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye inflammation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disease</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B or C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
<td></td>
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<tr>
<td>Kidney stones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleurisy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disease</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood clots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid on the lungs</td>
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<td></td>
</tr>
</tbody>
</table>

7a. **Have you noticed any:**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn or reflux</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry eyes or dry mouth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rash or change in skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot or leg swelling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity to light</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bruising</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint pain or swelling</td>
<td></td>
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</tr>
</tbody>
</table>
8. Have you ever smoked, inhaled, or injected “recreational” drugs? □ Yes □ No
(Include “street drugs” or crushed pills. Do not include prescribed inhalers.)

9. 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? _______ 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 grandparents, parents, brothers, sisters, aunts, uncles, cousins, or children 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 □ □
Sauna □ □
Hot tub/Jacuzzi □ □
Water damage □ □
Mold □ □
Animals □ □
Birds (include pigeons, doves, parakeets, cockaties, chickens, ducks, geese, pheasants) □ □

13. Have you ever had a chest X-ray or CT scan of the chest? □ Yes □ No

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? (Please list all locations where you lived for at least 6 months.)
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Outside this country? (Please indicate which countries.)
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
15. Have you lived or worked in environment where you were exposed to heavy smoke or dust?  □ Yes  □ No

16. Occupational history: Please include all occupations in your life.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Years worked</th>
<th>Exposures (Dust, metal, paint, fine particles, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>-----------------------------------------------------</td>
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<td>-----------------------------------------------------</td>
</tr>
</tbody>
</table>

17. Have you ever performed any of the following occupations?

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

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

- □ Mine
- □ Quarry
- □ Pulp mill
- □ Bakery
- □ Foundry
- □ Railroad
- □ Paper mill
- □ 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>
</tr>
<tr>
<td>□ Feathers</td>
<td>□ Cobalt</td>
<td>□ Maple Bark</td>
<td>□ Wood</td>
<td>□ Detergent (isocyanates)</td>
</tr>
<tr>
<td>□ Fishmeal</td>
<td>□ Tin</td>
<td>□ Wheat</td>
<td>□ Industrial strength cleaning solution</td>
<td>□ Pottery</td>
</tr>
<tr>
<td>□ Insecticide</td>
<td>□ Iron oxide</td>
<td>□ Coffee/ tea</td>
<td>□ Oily Nosedrops</td>
<td>□ Talc</td>
</tr>
<tr>
<td>□ Fertilizer</td>
<td>□ Aluminum</td>
<td>□ Mushroom</td>
<td></td>
<td>□ Paint</td>
</tr>
<tr>
<td></td>
<td>□ Mica</td>
<td>□ Oil</td>
<td></td>
<td>□ Cement</td>
</tr>
<tr>
<td></td>
<td>□ Silica</td>
<td>□ Sugar cane</td>
<td></td>
<td>□ Pipes</td>
</tr>
<tr>
<td></td>
<td>□ Asbestos</td>
<td>□ Malt</td>
<td></td>
<td>□ Brakes</td>
</tr>
<tr>
<td></td>
<td>□ Coal</td>
<td>□ Meat</td>
<td></td>
<td>□ Tile (ceramic)</td>
</tr>
</tbody>
</table>

20. List any other unusual exposures that you feel might be related to your lung disease.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
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, Sjögren’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. Medication history: 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
- Nilutamide
- Nitrosoureas
- Radiation
- Vinblastine

**Cardiovascular medications:**
- Amiodarone (Cordarone)
- Captopril (Capoten)
- Hydralazine
- Hydrochlorothiazide
- Procainamide (Procain SR)
- Sotolol

**Gastrointestinal medications:**
- Azulfidine
- Sulfasalazine

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

**Neurological medications:**
- Bromocriptine
- Carbamazepine (Tegretol)
- L tryptophan
- Phenytoin (Dilantin)

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