

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:

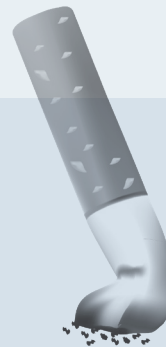
	YES	NO		YES	NO		YES	NO
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Sinus disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Fluid on the lungs	<input type="checkbox"/>	<input type="checkbox"/>
Eye inflammation	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>			

7a. Have you noticed any:

	YES	NO		YES	NO		YES	NO
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Rash or change in skin	<input type="checkbox"/>	<input type="checkbox"/>	Hand ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Foot or leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Mouth ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or reflux	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes or dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>



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 | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema, Chronic Obstructive Pulmonary Disease (COPD) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Sarcoidosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Cystic fibrosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Pulmonary fibrosis |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 | | YES | NO | |
|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Humidifier | <input type="checkbox"/> | <input type="checkbox"/> | Mold |
| <input type="checkbox"/> | <input type="checkbox"/> | Sauna | <input type="checkbox"/> | <input type="checkbox"/> | Animals |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot tub/Jacuzzi | <input type="checkbox"/> | <input type="checkbox"/> | Birds <i>(include pigeons, doves, parakeets, cockaties, chickens, ducks, geese, pheasants)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Water damage | | | |

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.

Occupation	Years worked	Exposures (Dust, metal, paint, fine particles, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

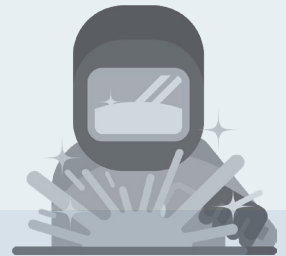


17. Have you ever performed any of the following occupations?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Farm work | <input type="checkbox"/> Automotive mechanic | <input type="checkbox"/> Carpenter |
| <input type="checkbox"/> Painter | <input type="checkbox"/> Welder | <input type="checkbox"/> Laboratory worker |
| <input type="checkbox"/> Sand blaster | <input type="checkbox"/> Insulator | <input type="checkbox"/> Longshoreman |
| <input type="checkbox"/> Pipe fitter | <input type="checkbox"/> Vineyard worker | |

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

- | | | |
|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Mine | <input type="checkbox"/> Foundry | <input type="checkbox"/> Plastic factory |
| <input type="checkbox"/> Quarry | <input type="checkbox"/> Railroad | <input type="checkbox"/> Tunnel construction |
| <input type="checkbox"/> Pulp mill | <input type="checkbox"/> Paper mill | |
| <input type="checkbox"/> Bakery | <input type="checkbox"/> Smelting | |



19. Have you ever been exposed to the following at work/ home/ elsewhere?

- | Animals and farming | Metals/rocks | Food/ plant Production | Miscellaneous | Skilled |
|--------------------------------------|-------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Birds | <input type="checkbox"/> Beryllium | <input type="checkbox"/> Cheese | <input type="checkbox"/> Cotton | <input type="checkbox"/> Cork |
| <input type="checkbox"/> Feathers | <input type="checkbox"/> Cobalt | <input type="checkbox"/> Maple Bark | <input type="checkbox"/> Wood | <input type="checkbox"/> Detergent (isocyanates) |
| <input type="checkbox"/> Fishmeal | <input type="checkbox"/> Tin | <input type="checkbox"/> Wheat | <input type="checkbox"/> Industrial strength cleaning solution | <input type="checkbox"/> Pottery |
| <input type="checkbox"/> Insecticide | <input type="checkbox"/> Iron oxide | <input type="checkbox"/> Coffee/ tea | <input type="checkbox"/> Oily Nosedrops | <input type="checkbox"/> Talc |
| <input type="checkbox"/> Fertilizer | <input type="checkbox"/> Aluminum | <input type="checkbox"/> Mushroom | | <input type="checkbox"/> paint |
| | <input type="checkbox"/> Mica | <input type="checkbox"/> Oil | | <input type="checkbox"/> Cement |
| | <input type="checkbox"/> Silica | <input type="checkbox"/> Sugar cane | | <input type="checkbox"/> Pipes |
| | <input type="checkbox"/> Asbestos | <input type="checkbox"/> Malt | | <input type="checkbox"/> Brakes |
| | <input type="checkbox"/> Coal | <input type="checkbox"/> Meat | | <input type="checkbox"/> Tile (ceramic) |



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, 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. 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

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 treatment:

- Cephalosporin
- Isoniazid (*INH*)
- Macrolide
- Minocycline
- Nitrofurantoin (*Macrochantin*)
- Penicillin
- Sulfonamides (*TMP-SMX*)

Cardiovascular medications:

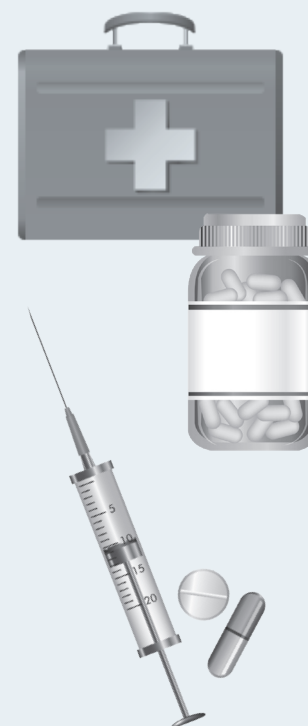
- Amiodarone (*Cordarone*)
- Captopril (*Capoten*)
- Hydralazine
- Hydrochlorothiazide
- Procainamide (*Procainal SR*)
- Sotalol

Gastrointestinal medications:

- Azulfidine
- Sulfasalazine

Neurological medications:

- Bromocriptine
- Carbamazepine (*Tegretol*)
- L tryptophan
- Phenytoin (*Dilantin*)



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