WOOLCOCK BREATHLESSNESS CLINIC

PATIENT QUESTIONNAIRE

WOOLCOCK
LEADERS IN BREATHING & SLEEP RESEARCH

YOUR DETAILS

Name: _____

Date of Birth: _____ Phone Number: _____

Email Address: _____

BREATHLESSNESS

Please bring the following to your appointment:
- **Contact details to any other specialists that you might see**
- **Previous chest x-rays**

How long have you been breathless for? *Please circle:*

Days / Weeks / Months / Years

Is your breathlessness changing? *Please circle:*

It's getting better / It's getting worse / It's staying the same / It changes every day

3 things that make you breathless *Please specify:*

1. _____

2. _____

3. _____

Which is the one that makes you the most breathless? _____

Intensity out of 10? _____

Unpleasantness out of 10? _____

How far can you walk on the flat? _____

What makes you stop?

☐ Breathing

☐ Something else - *please specify*: _____

Can you walk up 2 flights of stairs? ☐ Yes ☐ No

If no, what makes you stop?

☐ Breathing

☐ Something else - *please specify*: _____

ASSOCIATED SYMPTOMS *Please tick:*

Happens when breathless:

☐ Cough
☐ Wheeze
☐ Chest pain
☐ Chest tightness
☐ Other pain
☐ Tingling in hands
☐ Tingling around lips
☐ Something else - *please specify*: _____

Happens other times:

☐ Cough
☐ Wheeze
☐ Chest pain
☐ Chest tightness
☐ Other pain
☐ Tingling in hands
☐ Tingling around lips
☐ Something else - *please specify*: _____

WOOLCOCK
LEADERS IN BREATHING & SLEEP RESEARCH

Please tick which of the below best describes how it feels when you are breathless:

☐ Can't seem to get enough breath in ☐ It takes a lot of effort to get my breath in ☐ My chest feels tight

☐ Something else – *please specify*:_____ ☐ Not sure

ABOUT YOUR PREVIOUS HEALTH

Do you have high blood pressure OR are you on tablets for high blood pressure? *Please specify*:

_____

Do you have high cholesterol OR are you on tablets for high cholesterol? *Please specify*:

_____

Do you have diabetes OR are you on tablets for diabetes? *Please specify*:

_____

Have you had a heart attack, heart stent, stroke or mini stroke?_____

Has a close relative (mother, father, brother, sister) had a heart attack, heart stent, stroke or mini stroke?

How old were they when this happened?_____

_____

Do you smoke? ☐ Yes ☐ No

If Yes, how many years have you smoked for?_____**How many a day?**_____

Did you ever smoke? ☐ Yes ☐ No

If yes, how many years did you smoke for?_____

How old were you when you stopped?_____

How many did you smoke a day at your heaviest?_____

Do you have atrial fibrillation (AF)?_____

Did you have asthma when you were younger? ☐ Yes ☐ No

Does anyone in your family have asthma? ☐ Yes ☐ No

How tall are you?_____**How much do you weigh?**_____

What tests, if any, have you had for your breathing problem?_____

_____

_____

Do you know the results?_____

What treatment, if any, have you had for your breathing problem? Did they help?_____

_____

Please list your medications, including inhalers:_____

_____

_____

_____

_____

_____