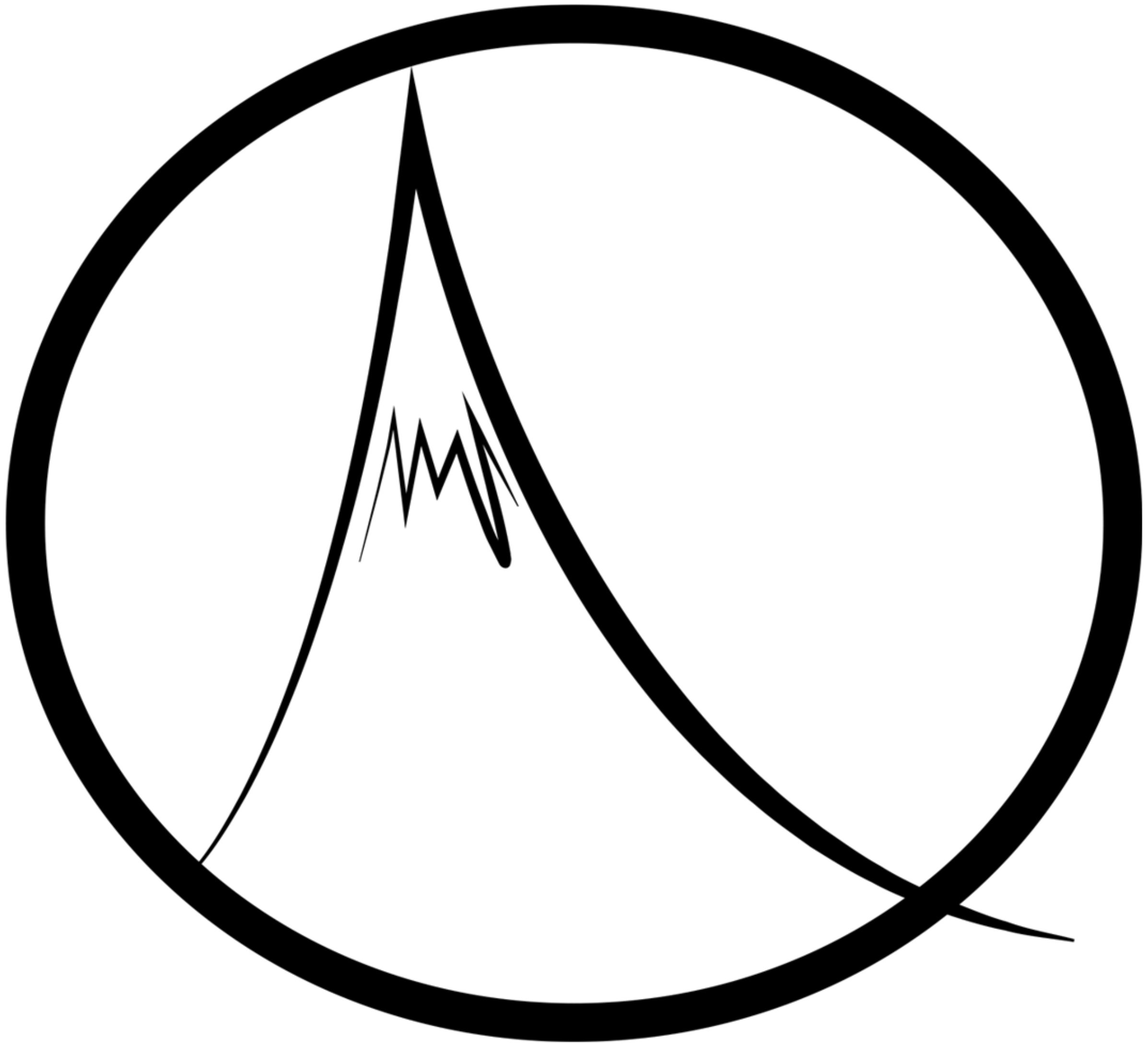
PEAK RESPIRATORY QUESTIONNAIRE
ADULT

Local and Toll Free Telephone and Fax:

1-855-PFT-PEAK(738-7325)



PEAK MEDICAL
•SPECIALTY CENTRES•

PEAK PULMONARY
•FUNCTION LABORATORIES•

www.peakpulmonary.com
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This section to be filled out by clinic staff	
Date:	BMI:
SPO2:	HR:
Ht (cm):	Wt (kg):

PATIENT LABEL OR NAME

PEAK RESPIRATORY QUESTIONNAIRE

Symptoms	
1	What best describes what your doctor would say about your lungs? ☐ COPD ☐ Asthma ☐ Cough ☐ Smoker at Risk ☐ Other(please specify):
2	What are your main breathing concerns/issues presently (symptoms)?
3	In what year did you first develop breathing problems? ________
4	Females only: Are you Pregnant? ☐ No ☐ Yes

History

1 Do you have a history of (check all that apply):

☐ Childhood Asthma ☐ Chest Illnesses ☐ Sleep Apnea ☐ Heart Disease ☐ Ankle Swelling (edema)
☐ High Blood Pressure ☐ Diabetes

2 Do you have a family history of lung disease? ☐ No (If No, proceed to #3) ☐ Yes (If Yes, check all that apply below)

Relationship	Asthma	COPD	Chronic Bronchitis	Lung Cancer	Emphysema	Other
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐

3

If you have Asthma please answer the following questions:	Yes	No
a. Do you have shortness of breath, cough, wheeze or experience chest tightness 4 or more days a week?	☐	☐
b. Does shortness of breath, coughing, wheezing or chest tightness wake you 1 or more night(s) a week?	☐	☐
c. Do you stop exercising because of your asthma?	☐	☐
d. Do you miss work or school because of your asthma?	☐	☐
e. Do you use your rescue medication (blue puffer) 4 or more times a week (except prior to exercise)?	☐	☐

4 Do you regularly experience the following or have you ever had any of the following conditions (check all that apply)?

☐ Hayfever ☐ Rhinitis ☐ Eczema ☐ Hives Sinusitis ☐ Nasal Polyps ☐ Allergies ☐ Allergy Testing
☐ Runny Nose ☐ Post Nasal Drip ☐ Nasal Congestion ☐ Sneezing ☐ Itchy, Watery Eyes

5 Which of the following are triggers for your asthma or breathing problems? Check all that apply.
Circle all triggers you are uncertain about.

☐ Air pollution	☐ Cold Air	☐ Grass/Trees/Weeds	☐ Strong Emotions (e.g. hard laugh)
☐ Animals	☐ Damp Places (mould)	☐ Infections/Colds/Viruses	☐ Strong Odours (i.e. paint, perfume)
☐ Aspirin	☐ Dust Mites	☐ Menstrual Cycle (Females)	☐ Weather Changes
☐ Certain Foods	☐ Exercise	☐ Occupational Chemicals	☐ Other (please specify):
☐ Cigarette Smoke	☐ Food Additives	☐ Pregnancy (Females)	

6 Do you experience heartburn or have gastroesophageal reflux (GERD)? ☐ Yes ☐ No

7 Do you have a pet in the home? ☐ No ☐ Yes If yes, how many and what kind?________________________

8 What is your occupation or work? ________________________
Do you find that your job or place of employment makes your breathing worse? ☐ No ☐ Yes ☐ Don't Know
If yes, what part (exposures)?

9

If you have COPD, Emphysema or Chronic Bronchitis please answer the following questions:	Yes	No
a. Do you cough regularly?	☐	☐
b. Do you cough up phlegm regularly?	☐	☐
c. Do even simple chores make you short of breath?	☐	☐
d. Do you wheeze when you exert yourself (exercise, climbing stairs)?	☐	☐
e. Do you get many colds and do your colds usually last longer than your friends' colds?	☐	☐

10	MRC Scale: If you have COPD, Emphysema or Chronic Bronchitis please check the one box that best describes your symptoms:		
	1	☐	Troubled by breathlessness except with strenuous exercise
	2	☐	Troubled by shortness of breath when hurrying on the level or walking up a slight hill
	3	☐	Walks slower than people of the same age on the level because of breathlessness or has to stop for breath when wal ing at own pace on the level
	4	☐	Stops for breath after walking about 100 yards (90 m) or after a few minutes on the level
	5	☐	Too breathless to leave the house or breathless when dressing or undressing
11	Have you had a:	Flu vaccine ☐ No ☐ Yes	Date of vaccine:
		Pneumonia vaccine ☐ No ☐ Yes	Date of vaccine:

12	How many times in the last 12 months have you:	# of Times
	a. Been to your doctor/walk-in clinic/emerg dept. for urgent treatment of your breathing or for a chest cold?	________
	b. Been hospitalized for your breathing or for a chest cold?	________
	c. Taken prednisone for treatment of your breathing or for a chest cold?	________
	d. Taken antibiotics for treatment of your breathing or for a chest cold?	________

13	If you have a chronic cough, please answer the following questions:				
	a. Where does your cough originate?	☐ Throat	☐ Chest		
	b. What time of day does your cough occur?	☐ Morning	☐ Afternoon	☐ Evening	☐ Night
	c. Is your cough productive (phlegm)?	☐ Yes	☐ No		
	d. Do you experience throat clearing?	☐ Yes	☐ No		

Smoking		
☐ Never Smoked If you are a current smoker or have ever smoked before, please answer the following questions:		
1	☐ Current Smoker (answer questions below)	☐ Former Smoker (answer questions below)
2	Over the years did you smoke: ☐ Daily; how many per day? ______________ ☐ Occasionally; how many per week? _________________ Presently how many cigarettes do you smoke/day?	Over the years did you smoke: ☐ Daily; how many per day? ______________ ☐ Occasionally; how many per week? _________________ Date you quit:
3	How old were you when you first started smoking?______	How old were you when you first started smoking? ______
Questions 4 to 7 are for Current Smokers only		
4	What medication have you tried in the past to quit? ☐ Champix ☐ Zyban ☐ Nicotine Patch ☐ Gum ☐ Lozenge ☐ Inhaler ☐ Spray Other (specify):	
5	Would you like to set a quit day? ☐ Yes (quit date: ________________) ☐ No	
6	What medication would you like to try for your quit attempt? ☐ Champix ☐ Zyban ☐ Nicotine Patch ☐ Gum ☐ Lozenge ☐ Inhaler ☐ Spray Other (specify):	
7	Does anyone in your home smoke? ☐ No ☐ Yes If yes, who? ___________________________________	

Epworth Sleepiness Scale

Please complete all questions below by circling the best number

How likely are you to doze off or fall asleep in the following circumstances, in contrast to just feeling tired?	Would Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. a theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Total				

Sleep	
How many hours do you sleep per night regularly?	What is the overall quality of your sleep? ☐ Good ☐ Not Good
Do you do shift work? ☐ Yes ☐ No	Do you wake up unrefreshed or with morning headaches? ☐ Yes ☐ No
Do you take sleeping aids (pills) or sedatives before bed? ☐ Yes ☐ No	Have you gained weight (10 pounds or more) over the last two years? ☐ Yes ☐ No
Do your legs bother you at night enough to have to get up and walk? ☐ Yes ☐ No	Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ☐ Yes ☐ No	Do you often feel tired, fatigued, or sleepy during waking hours? ☐ Yes ☐ No
Has anyone observed you stop breathing, choking or gasping during sleep? ☐ Yes ☐ No	What is your collar size?

I understand that the staff of Peak Pulmonary Consulting Inc. (PPCI) will be performing diagnostic testing as prescribed by my physician. I acknowledge that I have received information about the nature and purpose of the diagnostic testing. I do have the opportunity to ask questions and have those questions answered by the staff of PPCI. The diagnostic testing to be performed is strictly for my benefit and will be part of my health records. It will not be used for any research studies, advertising or any other purposes. I understand that this information will be kept confidential and not be for public consumption, and therefore authorize PPCI to collect and use information necessary to provide these diagnostic services. I also authorize PPCI to only refer my information to other health care professionals that they designate who require such information to provide additional health services for my benefit.

Print Name: ____________________ Signature: ________________________ Date: ____________________

End of Questionnaire. Thank you!

Medication (this section to be filled out by clinic staff)			
Respiratory Medications (Name/Dose/Frequency)			
ICS/LABA		Anticholinergics	
ICS		Nasal Spray/Rinse	
LABA		Oral corticosteroids	
Short-acting B-agonist		Oxygen	
LTRA		Other	
Other Medications			

Recommendations & Comments (this section to be filled out by clinic staff)