MAINLAND PULMONARY ASSOCIATES

LUNG HEALTH QUESTIONNAIRE

PATIENT INFORMATION:

Last Name:_____ First Name:_____ M.I.:_____
Date of Birth:_____ Age:_____ Sex: **M** **F**
Address:_____ City:_____ State:_____ Zip:_____
Home#:_____ Cell#:_____ Other#:_____

QUESTIONNAIRE:

1. Have you ever smoked? **YES** **NO** (If NO, please skip to question #10)
2. Choose ONE of the following:

   ___ I was _____ years old when I started smoking regularly.

   ___ I am only an occasional smoker and I started when I was _____ years old.
3. Do you currently smoke? **YES** **NO**
4. If you do <u>not</u> currently smoke, how old where you when you stopped? _____ years old _____N/A- I still smoke
5. On average, when you smoke(d) how many cigarettes do / did you smoke each day? _____/day
6. Which brand (s) do / did you smoke? _____
7. Approximately how many times have you tried to quit smoking?

   _____ NEVER _____ 1 TIME _____2 TIMES _____3-4 TIMES ____5 OR MORE TIMES
8. If you have tried to quit smoking, what methods have you used? Check ALL that apply.

   ___Quit on my own ___Quit with a relative/friend ___Gradually decreased number used ____ Psychiatrist/Psychologist

   ___Nicotine patch ___Free stop smoking program ___Used lower /low nicotine cigarettes ____ Hypnosis/Acupuncture

   ___Nicotine gum ___Paid stop smoking program ___Substituted other tobacco products

   ___Zyban ___Used special filters / holders ___ Vaping ____Other (specify) _____
9. What was the longest amount time that you were able to stop smoking (in total)?_____
10. Do you currently vape? **YES** **NO** How old were you when you started?_____ How often do you vape?_____
    _____
11. Do you add CBD oil to your vape? **YES** **NO**
12. Have you had a chest x-ray / CT scan within the last year? **YES** **NO**
13. Mark each of the following medical conditions that a doctor has said you either have now or have had in the past:

    ____ Heart Attack ____ Heart Failure ____ Kidney Failure ____ Liver Disease ____Cancer
    ____ Seizures ____ Bleeding Problems
14. Are you aware of family history of cancer? **YES** **NO** If YES Please specify:_____
15. Are you aware of breathing any harmful substances at work? **YES** **NO** If YES please specify:_____
16. Ethnicity (choose one): ___Caucasian ____Hispanic _____ African American ____Asian/Pacific Islander ___Other:_____
    _____

Today's Date:_____ Patient / Patient representative's signature: _____