Date:	Appt. time:	Arrival time:	Time in:	Time out:	Med Rec #:

PULMONARY FUNCTION STUDY

Patient completes this section

Name:	SSN:	DOB:
Address:	City:	State, Zip:
Phone (home):	(work):	Sex:
Employer:	Dept:	Job:
Race:	Height (in inches):	Weight (pounds):

		Yes	No
1.	Have you ever worn a respirator before?	☐	☐
2.	If yes, did you have any problems with it?	☐	☐
3.	Do you have asthma?	☐	☐
4.	Do you have any allergies?	☐	☐
5.	Do you have a heart condition or disease?	☐	☐
6.	Do you have a respiratory condition or disease?	☐	☐
7.	Do you smoke now?	☐	☐
8.	Did you smoke in the past?	☐	☐
9.	Do you wear glasses or contact lenses?	☐	☐
10.	Do you wear dentures?	☐	☐
11.	Have you ever had a seizure?	☐	☐
12.	Do you have diabetes?	☐	☐
13.	Do you have high blood pressure?	☐	☐
14.	Do you have a fear of tight or enclosed places?	☐	☐
15.	Do you take any medications?	☐	☐
16.	Do you have any other conditions that might interfere with respirator use or limit work ability? (If yes, indicate conditions here.)	☐	☐

Forced Vital Capacity (FVC)	
Forced Expiratory Volume (FEVI)	
Forced Expiratory Flow (FEF 25-75)	
Temperature (Celsius)	
Barometric pressure (mmHg)	

Comments

Do results need volume correction? ☐ Yes ☐ No

Test Effort ☐ Maximum ☐ Good ☐ Poor

Examined by _____ Date _____