UCLA Health System

Cardiopulmonary Rehabilitation Department

PULMONARY REHABILITATION PROGRAM
Patient Health Assessment Questionnaire

In order to prescribe the proper rehabilitation program to suit your individualized needs, please fill out the following questionnaire regarding your health.

Name: _____
(Last) (First) (Initial)

Address: _____
(Street Address)

_____
(City) (State) (Zip)

Date of Birth: _____ Age: _____ Email Address: _____

Emergency Contact Name & Phone: _____

Referring Physician & Phone: _____

Primary Physician & Phone: _____

Insurance: _____ Co-payment amount: _____ *(Due on date of service)*

Please briefly state, in your own words, why you were referred to this program: _____

_____

_____

Medications: Please list all prescribed *and* over-the-counter medications that you take. Please include the dose and number of times per day (or attach your already-prepared list).

Name	Dose	How Often?	Name	Dose	How Often?

Allergies: _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?	YES	NO
Breathless with strenuous exercise		
Short of breath when hurrying on the level or walking up a slight hill		
Walks slower than people of the same age on level ground because of breathlessness, or has to stop for breath when walking at own pace on level ground		
Stops for breath after walking about 100 yards or after a few minutes on level ground		
Too breathless to leave the house or when dressing or undressing		

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REVIEW OF SYSTEMS	YES	NO	NOT SURE/Comments
Please *make a check in the correct box and Please explain any "yes" in Comment Section*			
HAVE YOU EVER HAD?			
High blood pressure			
Heart attack			
Abnormal EKG			
Chest pain or Angina			
Heart valve problem			
Irregular heart beat or palpitations			
"Fluid on the lungs"-Congestive heart failure			
Swelling of ankles			
"Balloon Procedure" or stent-Angioplasty			
Pain in leg(s) when walking or active			
Pacemaker or defibrillator			
Anemia			
Recent cough,cold,fever,chills in the last 2 weeks			
Asthma			
Pneumonia in the last 2 months			
Emphysema			
Shortness of breath when lying down? How many pillows do you use?			
Use Oxygen at home? How many liters?			
Loud snoring or Sleep Apnea			
Use CPAP or BIPAP machine			
Pulmonary embolism(blood clot in lungs)			
Other lung or breathing problem			
Kidney failure/Hemodialysis/Peritoneal Dialysis			
Liver disease, cirrhosis			
Hepatitis or jaundice			
Transplant of Kidney/Liver/Pancreas			
Heartburn, acid reflux			
Difficulty swallowing or choking on food/drink			
Take diet medications now or in the past			
Recent weight loss of 20 lbs or more due to illness			
Ulcerative colitis? Last steroid use?			
Muscle disease			
Stroke or TIA ("mini-stroke")			
Seizures or Convulsions			
Hospitalizations in last year?			
Flu Vaccine			
Pneumonia Vaccine			
Do you use an assist device? (e.g. walker, cane, etc)			
Have you fallen recently? Please explain.			
Do you have pain? Where?			
Does your pain increase with activity?			
Diabetes			
If diabetic-how long?			
Range of morning glucose from low to high			
Insulin?			
Oral medication for diabetes?			
Current or past smoker			

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REVIEW OF SYSTEMS	YES	NO	NOT SURE/Comments
How many packs per day?			
How many years?			
If you quit, when was your quit date?			
If you have not, are you willing to quit?			
Exercise			
What type (swim, bike, walk, etc)			
How many days per week?			
How long is each exercise session?			
Would you call your exercise light, moderate, or strenuous?			

SURGERIES:

YEAR	SURGERY	WHERE
1		
2		
3		
4		

What activity of daily living can you no longer perform due to your pulmonary disease?

_____

What do you hope to achieve from this Pulmonary Rehab Program?

_____

Do you have an Advance Directive or Durable Power of Attorney for Healthcare? Y / N. If yes, is a copy in the system? Y / N. If no, please provide a copy. If No to first question, would like to receive information? _____

Do you have any cultural, spiritual or religious beliefs that might affect how we treat or teach you? _____

_____

Declaration of Commitment:

I, _____, am willing and motivated to enter UCLA's Pulmonary Rehabilitation Program, which includes a minimum of 2 days per week of supervised exercise and Pulmonary-related education, which will help me to better manage my lung disease. I am also committed to following the recommended prescribed home exercise program given to me by the Pulmonary Rehabilitation clinician. Finally, I am committed to maintain a non-smoking status, or, if I am a smoker, I will accept smoking cessation counseling and commit to quitting by the 3rd rehabilitation session.

Signature _____ **Date** _____