UCLA Health

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: _____ Date: _____
(Last) (First) (Initial)

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

Please briefly state why you were referred to this program: _____

_____

Please tell us what you would like to learn relative to your current health status/condition: _____

_____

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

_____

Do you have an Advanced Directive or Durable Power of Attorney?	Yes	No	
If "yes", is a copy in the system?	Yes	No	If "no," please provide us a copy.
If "no," would you like to receive information?	Yes	No	

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/or referral to a smoking cessation program.

Signature _____ Date _____

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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		

SURGERIES		
Year	**Surgery**	**WHERE**
1		
2		
3		
4		

REVIEW OF YOUR HEALTH STATUS	YES	NO	NOT SURE/Comments
Do you currently experience or have you had any of the following? Please place a check in the correct box. Please explain any "yes" in "Comments" Section.			
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," Angioplasty, and/or Stent			
Pain in leg(s) when walking or active			
Pacemaker or defibrillator			
Anemia			
Recent cough, cold, fever, or 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			

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REVIEW OF YOUR HEALTH STATUS (continued)	YES	NO	NOT SURE/Comments
Pulmonary embolism(blood clot in lungs)			
Other lung or breathing problem			
Current or past smoker			
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?			
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			
Are you under a Neurologist's care?			
Stroke or TIA ("mini-stroke")			
Seizures or Convulsions			
Orthopedic issues/concerns (i.e., low back, joint replacements, neck, shoulder, etc.)			
Have you fallen recently? Please explain.			
Do you use an assist device? (e.g. walker, cane, etc)			
Do you have Diabetes? *If "yes," how long?*			
Are you taking Insulin?			
Oral medication for diabetes?			
Range of morning glucose from low to high			
Have been hospitalized in the past year?			
Have you received the flu vaccine in the past year?			
Have you received the pneumonia vaccine?			
Does your current health status prevent you from your normal everyday activities?			
Does your current health status allow you to perform moderate physical activity or exercise (i.e., 30 minutes of walking at least 5 days a week)?			
Do you perform any other types of physical activity such as stretching, yoga, or strength training? If "yes," how many days a week and for how long do you do these types of activities?			

Please describe any other health issues you are experiencing that are not listed above.