### Chest Interstitial and Diffuse Lung Disease

**Patient Questionnaire**

1. **How often do you cough?**  
   *Note: Do not include clearing your throat.*
   - [ ] Not at all, or only rarely
   - [ ] Occasionally, but not bothersome
   - [ ] Most days
   - [ ] Often or in severe attacks that interfere with activity

2. **How long have you been coughing?**  
   ___ Months  ____ Years  ____ Not applicable

3. **Do you cough at night?**
   - [ ] Yes
   - [ ] No
   
   **3a. If you cough at night, does it awaken you?**
   - [ ] Yes
   - [ ] No

4. **The cough produces:** *Check all that apply.*
   - [ ] No phlegm
   - [ ] Phlegm
   - [ ] Blood
   - [ ] Don't cough

5. **Check the single number that describes the point at which you become short of breath:**
   - [ ] 1. I am not troubled with breathlessness except with strenuous exercise.
   - [ ] 2. I get short of breath when hurrying on level ground or walking up a slight hill.
   - [ ] 3. I walk slower than people of my age because of breathlessness or I have to stop from breath when walking on my own pace.
   - [ ] 4. I stop for breath after walking about 100 yards (90 meters) (or after a few minutes).
   - [ ] 5. I am too breathless to leave the house or breathless on dressing or undressing.

6. **When did your shortness of breath begin?** ________________.

7. **Has a doctor ever told you that you have?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Heart disease</td>
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<tr>
<td>Thyroid disease</td>
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<tr>
<td>Diabetes</td>
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<td>Sinus disease</td>
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<td>Stroke</td>
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<td>Seizure</td>
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<td>Eye inflammation</td>
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<td>Mononucleosis</td>
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<td>Hepatitis B or C</td>
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<td>Tuberculosis</td>
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<td>Kidney disease</td>
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<td>Kidney stones</td>
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<td>Blood in urine</td>
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<tr>
<td>Pleurisy</td>
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<td>Pneumonia</td>
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<td>Asthma</td>
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<td>Blood clots</td>
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<td>Pulmonary hypertension</td>
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<tr>
<td>Heart failure</td>
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<tr>
<td>Fluid on the lungs</td>
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</tbody>
</table>

7a. **Have you noticed any?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Weight loss</td>
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<tr>
<td>Difficulty swallowing</td>
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<tr>
<td>Heartburn or reflux</td>
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<tr>
<td>Dry eyes or dry mouth</td>
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<td>Rash or change in skin</td>
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<td>Foot or leg swelling</td>
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<tr>
<td>Sensitivity to light</td>
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<td></td>
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<tr>
<td>Bruising</td>
<td></td>
<td></td>
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<tr>
<td>Hand ulcers</td>
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<td>Mouth ulcers</td>
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<td>Chest pain</td>
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<td>Joint pain or swelling</td>
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</table>
8. **Have you ever smoked, inhaled, or injected “recreational” drugs?**
   (Include “street drugs” or crushed pills. Do not include prescribed inhalers.)  
   - [ ] Yes  
   - [ ] No

9. **Have you smoked 100 cigarettes (5 packs) or more in your life?**
   - [ ] Yes  
   - [ ] No
   **If yes,**
   - [ ] Do you smoke now?  
     - [ ] Yes  
     - [ ] No
   - [ ] How old were you when you started?  
     - _______ years old
   - [ ] Average number of cigarettes per day  
     - _______ cigarettes
   **If you quit,**
   - [ ] How old were you when you quit?  
     - _______ years old

10. **Do any of your grandparents, parents, brothers, sisters, aunts, uncles, cousins, or children have any of the following lung diseases?**
    - [ ] YES  
    - [ ] NO
    - [ ] Emphysema, Chronic Obstructive Pulmonary Disease (COPD)
    - [ ] Asthma
    - [ ] Sarcoidosis
    - [ ] Cystic fibrosis
    - [ ] Pulmonary fibrosis
    - [ ] Hypersensitivity pneumonitis

11. **Have you lived in an old house within the past 10 years?**  
    - [ ] Yes  
    - [ ] No

12. **Does your current or past home or work place have any of the following?**
    - [ ] YES  
    - [ ] NO  
    **Humidifier**
    **Sauna**
    **Hot tub/Jacuzzi**
    **Water damage**
    **Mold**
    **Animals**
    **Birds (include pigeons, doves, parakeets, cockaties, chickens, ducks, geese, pheasants)**

13. **Have you ever had a chest X-ray or CT scan of the chest?**  
    - [ ] Yes  
    - [ ] No
    **If yes,** please indicate the earliest and most recent you can remember:
    - **Earliest X-ray:** Year _____  
      Where? _______________________
    - **Most recent X-ray:** Year _____  
      Where? _______________________
    - **Earliest CT scan:** Year _____  
      Where? _______________________
    - **Most recent CT scan:** Year _____  
      Where? _______________________

14. **Where have you previously lived?** (Please list all locations where you lived for at least 6 months.)
    _____________________________________________________________________
    _____________________________________________________________________
    _____________________________________________________________________
    Outside this country? (Please indicate which countries.)
    _____________________________________________________________________
    _____________________________________________________________________
    _____________________________________________________________________
15. Have you lived or worked in environment where you were exposed to heavy smoke or dust?  
☐ Yes  ☐ No

16. Occupational history: Please include all occupations in your life.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Years worked</th>
<th>Exposures (Dust, metal, paint, fine particles, etc)</th>
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17. Have you ever performed any of the following occupations?

☐ Farm work  ☐ Automotive mechanic  ☐ Carpenter
☐ Painter  ☐ Welder  ☐ Laboratory worker
☐ Sand blaster  ☐ Insulator  ☐ Longshoreman
☐ Pipe fitter  ☐ Vineyard worker

18. Have you ever worked in any of the following locations?

☐ Mine  ☐ Foundry  ☐ Plastic factory
☐ Quarry  ☐ Railroad  ☐ Tunnel construction
☐ Pulp mill  ☐ Paper mill
☐ Bakery  ☐ Smelting

19. Have you ever been exposed to the following at work/ home/ elsewhere?

Animals and farming
☐ Birds  ☐ Feathers  ☐ Fishmeal
☐ Insecticide  ☐ Fertilizer

Metals/rocks
☐ Beryllium  ☐ Cobalt  ☐ Tin
☐ Iron oxide  ☐ Aluminum  ☐ Mica
☐ Silica  ☐ Asbestos  ☐ Coal

Food/ plant Production
☐ Cheese  ☐ Maple Bark  ☐ Wheat
☐ Coffee/ tea  ☐ Mushroom  ☐ Oil
☐ Sugar cane  ☐ Malt  ☐ Meat

Miscellaneous
☐ Cotton  ☐ Wood  ☐ Industrial strength cleaning solution
☐ Oily Nosedrops

Skilled
☐ Cork  ☐ Detergent (isocyanates)  ☐ Pottery
☐ Talc  ☐ Paint  ☐ Cement
☐ Pipes  ☐ Brakes  ☐ Tile (ceramic)

20. List any other unusual exposures that you feel might be related to your lung disease?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
21. Have you had any of the following medical problems?

- Pneumothorax *(collapsed lung)*
- Bleeding disorder
- Vasculitis *(inflammation of the blood vessels)*
- Raynaud’s phenomenon *(fingers painful and turning colors on cold exposure)*
- Rheumatologic disease *(This includes rheumatoid arthritis, lupus, scleroderma, mixed connective tissue disease, Sjogren’s Syndrome, Wegener’s, Polymyositis or dermatomyositis, Bechet’s disease, Ankylosing spondylitis.)*
- Bowel disease *(This includes Crohn’s Disease, Ulcerative colitis, Primary biliary cirrhosis, celiac or Whipple’s disease.)*

22. Medication history: Have you ever taken any of the following medications?

**Anti-inflammatory medications:**
- Azathiaprine *(Imuran)*
- Chlorambucil
- Colchicine
- Gold salts
- Interferon *(any)*
- Methotrexate
- Penicillamine
- Prednisone

**Antibiotics/ infection treatment:**
- Cephalosporin
- Isoniazid *(INH)*
- Macrolide
- Minocycline
- Nitrofurantoin *(Macrodantin)*
- Penicillin
- Sulfonamides *(TMP-SMX)*

**Cancer therapy:**
- Busulfan
- Bleomycin
- Cyclophosphamide
- Etoposide
- GMCSF
- Mitomycin
- Nilutamide
- Nitrosoureas
- Radiation
- Vinblastine

**Cardiovascular medications:**
- Amiodarone *(Cordarone)*
- Captopril *(Capoten)*
- Hydralazine
- Hydrochlorothiazide
- Procainamide *(Procain SR)*
- Sotolol

**Gastrointestinal medications:**
- Azulfidine
- Sulfasalazine

**Miscellaneous medications:**
- Fenfluramine/ dexfenfluramine
- Leukotriene inhibitor *(Singulaire, Accolate)*
- Propylthiouracil
- Bladder BCG

**Neurological medications:**
- Bromocriptine
- Carbamazepine *(Tegretol)*
- L tryptophan
- Phenytoin *(Dilantin)*

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