665 Bay Rd, Unit D, Dover, DE 19901
phone (302) 678-1303 fax (302)736-4332

800 N. DuPont Blvd, Milford, DE 19963
phone (302) 430-5705 fax (302)430-5679

18383 Hudson Rd, Milton, DE 19968
phone (302) 684-3812 fax (302) 725-3490

Patient Label

PRE-PFT QUESTIONNAIRE

1. **Are you feeling alright today?** ☐ YES ☐ NO
   (If no, postpone the test for at least 3 days, any acute illness might affect his/her ability to take a deep breath or to blow out forcefully.)

2. **Have you smoked any cigarettes, pipes, or cigars within the last hour?** ☐ YES ☐ NO

3. **Have you used any inhaled medications, such as an aerosolized bronchodilator within the last hour?** ☐ YES ☐ NO
   (If yes to either, postpone the test at least 1 hour as this can have a short-term effect on the small airways)

4. **Have you eaten a heavy meal in the past hour?** ☐ YES ☐ NO
   (If yes, postpone testing for 1 hour. A heavy meal may have a short-term effect on one's ability to take the deepest breath possible.)

5. **Have you had any lung infections such as the flu, pneumonia, bronchitis, or perforated eardrum within the last 3 weeks?** ☐ YES ☐ NO
   (If yes, postpone testing for at least 3 weeks after the symptoms have passed as such illnesses may have a short-term effect on the airways and/or cause ear discomfort during forceful expiration.)

6. **Have you had any recent surgeries?** ☐ YES ☐ NO
   (If the subject has had any major surgeries including oral surgeries and/or eye surgery, consult with the surgeon to determine how long to postpone the test. The subject's ability to take a deep breath or to obtain a tight seal around the mouthpiece may be temporarily affected.)

7. **Are you in your last trimester of pregnancy?** ☐ YES ☐ NO
   (If yes, do not perform test, as the later stages of pregnancy may affect the subject's ability to take a full deep breath.)

Patient Signature: _____ **Date:**____/_____/_____ **Time:**_____

OFFICE USE ONLY:

Blood Pressure: _____ ☐ Manual ☐Automatic **Arm**: ☐ Right ☐ Left

Height: _____ **Weight:**_____ **(kg)**

Provider consulted: Yes ☐ No ☐

If yes, provider comments: _____

_____

_____ **Date:**____/_____/_____ **Time:**_____

Provider's Signature