Better Breathing Survey

Please help us provide the best care to you and your lungs by filling out this short survey.

Please check off the option below that best describes your history of tobacco use

- ☐ Tobacco - Current User (includes daily and non-daily tobacco use)
- ☐ Tobacco - Former User (quit using tobacco however, had used tobacco at least 100 times in their lifetime)
- ☐ Tobacco - Never a User (used tobacco less than 100 times in your lifetime)

If you used tobacco what form do/did you use?

- ☐ Cigarettes
- ☐ Cigar/Pipe
- ☐ Spit/Chew
- ☐ E-Cigarette
- ☐ Other form

If you answered yes to tobacco use or former user, please answer the following:

Are you over the age of 40?

Yes_____ No_____

If you are a current (daily or non-daily) or former tobacco user, and are over the age of 40 please answer the following:

Do you cough regularly? ☐ Yes ☐ No

Do you cough up phlegm regularly? ☐ Yes ☐ No

Do even simple chores make you short of breath? ☐ Yes ☐ No

Do you wheeze when you exert yourself or at night? ☐ Yes ☐ No

Do you get frequent colds that persist longer than those of other people? ☐ Yes ☐ No

Has your provider sent you for a breathing test (Spirometry test) in the past?

Yes_____ No_____

If yes, when did you have your Spirometry test? _____

If you are a current tobacco user, are you interested in help to stop?

Yes_____ No_____

Thanks for completing this survey. Please hand it to your healthcare provider.

OFFICE USE ONLY

Spirometry on file ☐ Yes ☐ No

Smoking status already documented

☐ Yes ☐ No

Referred to Spirometry today

☐ Yes ☐ No ☐ Patient Declined

Follow up appointment needed

☐ Yes ☐ No