UCSF Medical Center

STAFF ONLY:
ILD ID#: _____ Visit Date: _____

INITIAL QUESTIONNAIRE FORM

PATIENTS: Please complete this questionnaire BEFORE coming to the ILD Clinic.
Please remember to arrive at least 30 minutes prior to your scheduled appointment time.

DEMOGRAPHICS

NAME: _____ _____ ____
Last name *First* *M.I.*

Address: *Street:* _____

City : _____ *State*: _____ *Zip Code*: _____

Date of Birth: ___ / ____ / _____ *(mm/dd/yy)* **Social Security Number**: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Gender: ☐ Male ☐ Female **Ethnicity**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ White ☐ Asian ☐ Native Hawaiian or other Pacific Islander
☐ Black/African American ☐ American Indian/Alaska Native ☐ Other

CONTACTS

Referring Physician

Name: _____ Specialty: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Phone: (____) _____ Fax: (____) _____

Other physicians who should receive reports from our clinic

Name: _____ Specialty: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Phone: (____) _____ Fax: (___) _____

Name: _____ Specialty: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Phone: (____) _____ Fax: (___) _____

SYMPTOMS

1. Do you cough? ☐ Yes ☐ No (This includes any cough,even if there is no phlegm. Do not include clearing your throat)

If "**YES**": A. When did the cough start? _____ (*mm,yyyy*)

B. Do you bring up phlegm? ☐ Yes ☐ No

C. Do you bring up blood? ☐ Yes ☐ No

D. Have you ever coughed up blood? ☐ Yes ☐ No

E. Since your cough began, it is: ☐ Better ☐ Worse ☐ The Same

2. Does your chest ever sound wheezy or whistling? ☐ Yes ☐ No

3. For each activity listed below, please rate your breathlessness on a scale of 0 to 5, where 0 is not at all breathless and 5 is maximally breathless or too breathless to do the activity.
Your responses should be for an average day during the past week. If the activity is one which you do not perform, please give your best estimate of breathlessness. Please respond to all items.

How short of breath do you get while:

1. At rest	0	1	2	3	4	5
2. Walking on a level at your own pace	0	1	2	3	4	5
3. Walking on a level with others your age	0	1	2	3	4	5
4. Walking up a hill	0	1	2	3	4	5
5. Walking up stairs	0	1	2	3	4	5
6. While eating	0	1	2	3	4	5
7. Standing up from a chair	0	1	2	3	4	5
8. Brushing teeth	0	1	2	3	4	5
9. Shaving and/or brushing hair	0	1	2	3	4	5
10. Showering/bathing	0	1	2	3	4	5
11. Dressing	0	1	2	3	4	5
12. Picking up and straightening	0	1	2	3	4	5
13. Doing dishes	0	1	2	3	4	5
14. Sweeping/vacuuming	0	1	2	3	4	5
15. Making the bed	0	1	2	3	4	5
16. Shopping	0	1	2	3	4	5
17. Doing laundry	0	1	2	3	4	5
18. Washing the car	0	1	2	3	4	5
19. Mowing the lawn	0	1	2	3	4	5
20. Watering the lawn	0	1	2	3	4	5
21. Sexual activities	0	1	2	3	4	5

How much do these limit you in your daily life?

22. Shortness of breath	0	1	2	3	4	5
23. Fear of hurting myself by overexerting	0	1	2	3	4	5
24. Fear of shortness of breath	0	1	2	3	4	5

4. The questions below are designed to determine how much you can do before you become short of breath. If any of the activities listed in these questions make you short of breath, then answer "Yes" to that question

A. 30 minutes of vigorous activity (such as aerobics, distance running), or lifting and carrying greater than 60 pounds for several minutes.	☐ Yes	☐ No
B. 10 minutes of vigorous activity (such as using heavy tools), climbing 5 flights of stairs.	☐ Yes	☐ No
C. Less than 10 minutes of vigorous activity, walking 1 to 3 miles on level ground, climbing 3 flights of stairs, heavy general labor.	☐ Yes	☐ No
D. Walking ¼ to 1 mile on level ground, climbing 2 flights of stairs, after activity such as paper hanging.	☐ Yes	☐ No
E. Walking 400 feet to ¼ mile (or after a few minutes) on level ground, or other activity (such as bed making).	☐ Yes	☐ No
F. Walking 150-300 feet on level ground, 1 flight of stairs, activity such as scrubbing, truck driving, assembly line work.	☐ Yes	☐ No
G. Walking 50 to 100 feet on level ground, light janitorial work.	☐ Yes	☐ No
H. Walking 20 to 50 feet on level ground, light standing work at your own pace, sitting operation of heavy equipment.	☐ Yes	☐ No
I. Walking less than 20 feet (too breathless to leave the house), dressing or undressing, prolonged talking.	☐ Yes	☐ No
J. Minimal Activity (eating, defecating, writing, sitting up, using small utensils).	☐ Yes	☐ No
K. Sitting at rest.	☐ Yes	☐ No

5. How did your shortness of breath begin? ☐ Suddenly ☐ Gradually

6. Since your shortness of breath started, it is: ☐ Better ☐ Worse ☐ The same

7. Do you have repeated sudden attacks of shortness of breath? ☐ Yes ☐ No

8. Do you have difficulty walking because of conditions other than your lung disease? ☐ Yes ☐ No

9. If you experience any of the symptoms listed below, please answer "Yes" and provide an approximate date (month and year) the symptom started and any other information requested.

A. Fatigue ☐ Yes ☐ No Date: _____

B. Joint stiffness, pain, or swelling ☐ Yes ☐ No Date: _____

Joints involved: ☐ Hands/wrists ☐ Shoulders ☐ Knees ☐ Ankles/feet ☐ Other: _____

C. Difficulty swallowing or food getting stuck in your throat ☐ Yes ☐ No Date: _____

D. Persistently dry eyes or dry mouth ☐ Yes ☐ No Date: _____

E. Pain or color change (white/red) in fingers with cold weather ☐ Yes ☐ No Date: _____

F. Recurrent fever ☐ Yes ☐ No Date: _____

G. Weight loss ☐ Yes ☐ No Weight loss amount (pounds): _____ Date: _____

H. Heartburn, reflux, or sour taste in mouth after eating ☐ Yes ☐ No Date: _____

I. Snoring, morning headaches, or excessive daytime sleepiness ☐ Yes ☐ No Date: _____

J. Rash ☐ Yes ☐ No Date: _____

K. Ulcers in the mouth or vagina ☐ Yes ☐ No Date: _____

OTHER MEDICAL HISTORY

10. The following questions ask about other medical conditions you may have. If you have ever been told that you have the following conditions, answer "Yes" and give the year diagnosed.

A. Asthma	☐ Yes	☐ No	Date: _____
B. Chronic obstructive pulmonary disease (COPD) (includes emphysema and chronic bronchitis)	☐ Yes	☐ No	Date: _____
C. Heart Failure	☐ Yes	☐ No	Date: _____
D. Rheumatoid Arthritis	☐ Yes	☐ No	Date: _____
E. Scleroderma, systemic sclerosis, or CREST syndrome	☐ Yes	☐ No	Date: _____
F. Systemic Lupus Erythematosis	☐ Yes	☐ No	Date: _____
G. Polymyositis or Dermatomyositis	☐ Yes	☐ No	Date: _____
H. Sjogren's Syndrome	☐ Yes	☐ No	Date: _____
I. Gastroesophageal reflux disease (GERD) or hiatal hernia	☐ Yes	☐ No	Date: _____
J. Obstructive sleep apnea	☐ Yes	☐ No	Date: _____
K. Immune system disorder (such as low gamma globulin levels)	☐ Yes	☐ No	Date: _____
L. Pulmonary hypertension	☐ Yes	☐ No	Date: _____
M. Diabetes	☐ Yes	☐ No	Date: _____

Please list any other medical problems: _____

_____

_____

12. The following statements refer to symptoms of gastroesophageal reflux disease (GERD). Please circle how frequently you experience each of the symptoms below:

	Never	Occasionally	Sometimes	Often	Always
A. Do you get heartburn?	0	1	2	3	4
B. Does your stomach get bloated?	0	1	2	3	4
C. Does your stomach ever feel heavy after meals?	0	1	2	3	4
D. Do you sometimes subconsciously rub your chest with your hand?	0	1	2	3	4
E. Do you ever feel sick after meals?	0	1	2	3	4
F. Do you get heartburn after meals?	0	1	2	3	4
G. Do you have an unusual (e.g. burning) sensation in your throat?	0	1	2	3	4
H. Do you feel full while eating meals?	0	1	2	3	4
I. Do some things get stuck when you swallow?	0	1	2	3	4
J. Do you get bitter liquid (acid) coming up into your throat?	0	1	2	3	4
K. Do you burp a lot?	0	1	2	3	4
L. Do you get heartburn if you bend over?	0	1	2	3	4

FAMILY HISTORY

13. Does anyone in your family have a history of pulmonary fibrosis (lung scarring)? ☐ Yes ☐ No Who: _____

14. Does anyone in your family have a history of autoimmune disease (for example: rheumatoid arthritis, lupus, or scleroderma)? ☐ Yes ☐ No Who: _____

SMOKING/DRUG HISTORY

15. Have you ever smoked cigarettes? ☐ Yes ☐ No

If "Yes", answer A-D. If "No", move to question 16.

A. Do you smoke cigarettes now? (*at least one cigarette a day for the past year*) ☐ Yes ☐ No

B. What year did you start smoking? _____

C. What year did you stop smoking? _____ (if you are still smoking, mark N/A) ☐ N/A

D. On average, how many cigarettes do/did you smoke per day? _____

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16. Have you ever lived in the same house with someone who smoked regularly for at least one year? ☐ Yes ☐ No

17. Have you ever smoked one or more cigars a week for a year? ☐ Yes ☐ No # of years: ____
If yes, list the number of years you have smoked cigars.

18. Have you ever smoked a pipe (more than 12 oz tobacco in your life)? ☐ Yes ☐ No # of years: ____
If yes, list the number of years you have smoked pipes.

19. Have you ever smoked marijuana? ☐ Yes ☐ No

20. Have you ever used cocaine? ☐ Yes ☐ No

21. Have you ever used intravenous drugs? ☐ Yes ☐ No

ENVIRONMENTAL HISTORY

22. The following questions ask about specific exposures you may have had in your home environment. If you were REGULARLY OR REPEATEDLY exposed to any of the following in the THREE YEARS BEFORE your breathing problem started, answer "Yes" and provide any additional information requested.

A. Humidifier ☐ Yes ☐ No

B. Air cleaner/purifier ☐ Yes ☐ No

C. Steam sauna/steam shower ☐ Yes ☐ No

D. Indoor hot tub ☐ Yes ☐ No

E. Swamp cooler ☐ Yes ☐ No

F. Water damage or mold/mildew in the home ☐ Yes ☐ No

G. Asbestos ☐ Yes ☐ No

H. Down pillows or comforters ☐ Yes ☐ No

I. Pigeons,parakeets or other birds ☐ Yes ☐ No Kind: _____

J. Dogs, cats, rabbits, gerbils, hamsters or guinea pigs in house ☐ Yes ☐ No Kind: _____

K. Does the house or office smell musty? ☐ Yes ☐ No

L. Has there been a history of flooding? ☐ Yes ☐ No

M. Is there water damage on the walls or ceilings? ☐ Yes ☐ No If yes, take digital pictures

N. Do you have a lot of plants in the house or office? ☐ Yes ☐ No

O. Do you have fish tanks? ☐ Yes ☐ No

P. Are there any appliances or sinks that leak water or have a water pan to change? ☐ Yes ☐ No

Q. Does your dishwasher leak/overflow? ☐ Yes ☐ No

R. Do you own a Sleep-Number (or equivalent) bed? ☐ Yes ☐ No

S. Do any leather clothes or shoes stored in the closets have a fine layer of white or black covering them? ☐ Yes* ☐ No * If yes, take digital pictures

T. Are the walls of the closets discolored or do they have a film of black or white covering them? ☐ Yes* ☐ No * If yes, take digital pictures

U. Do you have carpeting? If so, how old is it? ____ ☐ Yes ☐ No
Do you get it steam-cleaned regularly? ☐ Yes ☐ No

V. Do you work with potting soils or compost on a regular basis? ☐ Yes ☐ No

W. Do you hunt in duck blinds or have exposure to moist soil? ☐ Yes ☐ No

OCCUPATIONAL HISTORY

23. The following questions ask about specific jobs or hobbies you may have had in your life. If you have ever worked as one of the following, answer "Yes" and provide the average level of dust exposure you experienced during that time.

A. Pottery worker ☐ Yes ☐ No
B. Cotton mill worker ☐ Yes ☐ No
C. Pipe worker/plumber ☐ Yes ☐ No
D. Insulation worker ☐ Yes ☐ No
E. Farmer ☐ Yes ☐ No
F. Sandblaster ☐ Yes ☐ No
G. Rock miner ☐ Yes ☐ No
H. Talc worker ☐ Yes ☐ No
I. Beryllium worker ☐ Yes ☐ No
J. Aluminum worker ☐ Yes ☐ No
K. Carpenter/woodwork ☐ Yes ☐ No
L. Plastic worker ☐ Yes ☐ No
M. Mica worker ☐ Yes ☐ No
N. Railroad worker ☐ Yes ☐ No
O. Painter/spray painting ☐ Yes ☐ No
P. Longshoreman ☐ Yes ☐ No
Q. Housecleaner ☐ Yes ☐ No
R. Smelter/Foundry work ☐ Yes ☐ No
S. Welder ☐ Yes ☐ No
T. Textile worker ☐ Yes ☐ No
U. Paper product worker ☐ Yes ☐ No
V. Cement/ cement product worker ☐ Yes ☐ No
W. Road builder/tunnel construction work ☐ Yes ☐ No
X. Automotive product worker (brake linings, gaskets, clutch plates,etc) ☐ Yes ☐ No
Y. Insulation worker (pipe/boiler, bulkhead linings, filler, grouting) ☐ Yes ☐ No

24. Have you ever worked in a dusty environment? ☐ Yes ☐ No

25. Have you ever been exposed to gas fumes or chemicals? ☐ Yes ☐ No

MEDICATION HISTORY

26. The following questions ask about specific medications. If you are taking or have ever taken the listed medication, please answer "Yes" and provide the year you began taking this medication.

A. Amiodarone (Cordarone®)	☐ Yes	☐ No	Date: _____
B. Nitrofurantoin (Macrobid, Macrodantin®)	☐ Yes	☐ No	Date: _____
C. Bleomycin (Blenoxane®)	☐ Yes	☐ No	Date: _____
D. Methotrexate (Folex®, Rheumatrex®)	☐ Yes	☐ No	Date: _____
E. Prednisone/prednisolone	☐ Yes	☐ No	Date: _____
F. Cyclophosphamide (Cytoxan®)	☐ Yes	☐ No	Date: _____
G. Azathioprine (Imuran®)	☐ Yes	☐ No	Date: _____
H. N-acetylcysteine (NAC)	☐ Yes	☐ No	Date: _____
I. Gamma-interferon 1-b (Actimmune®)	☐ Yes	☐ No	Date: _____
J. Mycophenolate (CellCept®)	☐ Yes	☐ No	Date: _____
K. Colchicine	☐ Yes	☐ No	Date: _____
L. Bosentan (Tracleer®)	☐ Yes	☐ No	Date: _____
M. Imatinib mesylate (Gleevec®)	☐ Yes	☐ No	Date: _____
N. Etanercept (Enbrel®)	☐ Yes	☐ No	Date: _____
O. Infliximab (Remicade®)	☐ Yes	☐ No	Date: _____
P. Radiation therapy	☐ Yes	☐ No	Date: _____
Q. Cancer chemotherapy	☐ Yes	☐ No	Date: _____
R. Busulfan (Busulphan®)	☐ Yes	☐ No	Date: _____
S. Diphenylhydantoin (Dilantin®)	☐ Yes	☐ No	Date: _____
T. Sulfasalazine (Azulfadine®)	☐ Yes	☐ No	Date: _____
U. Penicillamine (Cuprimine®, Depen®)	☐ Yes	☐ No	Date: _____
V. Hydralazine	☐ Yes	☐ No	Date: _____
W. Isoniazid (INH, Nydrazid®)	☐ Yes	☐ No	Date: _____
X. Procainamide (Procan, Promine,Pronestyl®)	☐ Yes	☐ No	Date: _____
Y. Chlorambucil (Leukeran®)	☐ Yes	☐ No	Date: _____
Z. Gold salts	☐ Yes	☐ No	Date: _____
AA. Cyclosporin A (Neoral® Sandimmune)	☐ Yes	☐ No	Date: _____

27. Please list your <u>current</u> medications and dosages (please attach list if needed):

_____ _____

_____ _____

_____ _____

_____ _____

SF-36 Assessment

1 In general, would you say your health is:

☐1 Excellent ☐2 Very good ☐3 Good ☐4 Fair ☐5 Poor

2 Compared to one year ago, how would you rate your health in general now?

☐1 Much better than one year ago ☐3 About the same as one year ago ☐5 Much worse now than one year ago

☐2 Somewhat better than one year ago ☐4 Somewhat worse than one year ago

3 The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	**Yes, Limited A Lot**	**Yes, Limited A Little**	**No, Not Limited At All**
a. **Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports	☐1	☐2	☐3
b. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐1	☐2	☐3
c. Lifting or carrying groceries	☐1	☐2	☐3
d. Climbing **several** flights of stairs	☐1	☐2	☐3
e. Climbing **one** flight of stairs	☐1	☐2	☐3
f. Bending, kneeling or stooping	☐1	☐2	☐3
g. Walking **more than a mile**	☐1	☐2	☐3
h. Walking **several blocks**	☐1	☐2	☐3
i. Walking **one block**	☐1	☐2	☐3
j. Bathing or dressing yourself	☐1	☐2	☐3

4 During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	**All of the Time**	**Most of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
a. Cut down on the **amount of time** you spend on work or other activities	☐1	☐2	☐3	☐4	☐5
b. **Accomplished less** than you would like	☐1	☐2	☐3	☐4	☐5
c. Were limited in the **kind** of work or other activities	☐1	☐2	☐3	☐4	☐5
d. Had **difficulty** performing the work or other activities *(for example, it took extra effort)*	☐1	☐2	☐3	☐4	☐5

5 During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	**All of the Time**	**Most of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
a. Cut down on the **amount of time** you spend on work or other activities	☐1	☐2	☐3	☐4	☐5
b. **Accomplished less** than you would like	☐1	☐2	☐3	☐4	☐5
c. Did work or other activities **less carefully than usual**	☐1	☐2	☐3	☐4	☐5

SF-36 Assessment (continued)

6 During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

☐1 Not at all ☐2 Slightly ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

7 How much bodily pain have you had during the past 4 weeks?

☐1 None ☐2 Very mild ☐3 Mild ☐4 Moderate ☐5 Severe ☐6 Very severe

8 During the past 4 weeks, how much did pain interfere with your normal work *(including both work outside the home and housework)*?

☐1 Not at all ☐2 Slightly ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

9 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...	All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of life?	☐1	☐2	☐3	☐4	☐5
b. Have you been very nervous?	☐1	☐2	☐3	☐4	☐5
c. Have you felt so down in the dumps that nothing could cheer you up?	☐1	☐2	☐3	☐4	☐5
d. Have you felt calm and peaceful?	☐1	☐2	☐3	☐4	☐5
e. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5
f. Have you felt downhearted and depressed?	☐1	☐2	☐3	☐4	☐5
g. Did you feel worn out?	☐1	☐2	☐3	☐4	☐5
h. Have you been happy?	☐1	☐2	☐3	☐4	☐5
i. Did you feel tired?	☐1	☐2	☐3	☐4	☐5

10 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities *(like visiting friends, relatives, etc.)*?

☐1 All of the time ☐2 Most of the time ☐3 Some of the time ☐4 A little of the time ☐5 None of the time

11 How **True** or **False** is each of the following statements for you?	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	☐1	☐2	☐3	☐4	☐5
b. I am as healthy as anybody I know	☐1	☐2	☐3	☐4	☐5
c. I expect my health to get worse	☐1	☐2	☐3	☐4	☐5
d. My health is excellent	☐1	☐2	☐3	☐4	☐5

Thank you for completing this questionnaire. We appreciate your time and effort!