HELEN HAYES HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

Pulmonary Rehabilitation Participant Questionnaire

Name: _____ Date: _____

Age: _____ Date of Birth: _____

To better help us set appropriate goals of treatment for you, please answer the following by checking off and filling in what applies to you. Thank you.

LIVING ENVIRONMENT ☐ House ☐ Apartment ☐ Mobile Home ☐ Condo

Above is: ☐ Single Level ☐ Multi Level

Entrance: ☐ Flat ☐ Ramp/Incline ☐ Stair(s)/# of stairs: _____

Inside: if Multi Level, # of stair(s) need to perform _____

- Able to perform? ☐ Yes ☐ No
- If yes, do you require any rest breaks while performing and how many? _____

HOUSEHOLD DUTIES Usual household duties I perform: ☐ Cooking ☐ Grocery shopping ☐ Cleaning ☐ Laundry ☐ Yard work ☐ Taking out garbage

I am able to perform those duties checked off above:

☐ Without difficulty
☐ With shortness of breath
☐ With needed rest breaks due to fatigue
☐ I am currently unable to perform any

ACTIVITIES OF DAILY LIVING I have difficulty performing: ☐ Bathing/showering ☐ Dressing ☐ Grooming

I have difficulty performing these activities because of: _____

EQUIPMENT/ASSISTIVE DEVICE(S) USED ☐ Walker ☐ Wheelchair ☐ Cane ☐ 4 point cane ☐ Scooter ☐ Eyeglasses ☐ Hearing Aide ☐ Oxygen

Do you have any physical limitations that may affect your ability to exercise? (sensory loss, amputation, stroke, fractures, etc.)

_____

EDUCATION The last grade or level of schooling I completed was: _____

I learn information best by: ☐ Explanation ☐ Reading ☐ Video/TV ☐ Computer ☐ Demonstration

OCCUPATION Current or former occupation: _____

☐ Retired ☐ On disability with plan to return ☐ On disability without plan to return ☐ Working

Physical exertion required? ☐ No ☐ Yes; intensity: ☐ mild ☐ moderate ☐ vigorous

SMOKING HISTORY ☐ I have never smoked ☐ *I quit smoking more than 6 months ago ☐ *I am a recent smoker (quit 1-6 months ago) ☐ *I am a current smoker (active smoker or quit within last month)

*For above: Year quit: _____ # Years smoked: _____ Packs smoked per day: _____

If you are still smoking do you plan to quit? ☐ Yes ☐ No

EXERCISE HISTORY ☐ I am sedentary ☐ I currently do purposeful exercise:

Type: _____ Number of days/week _____ Number of minutes _____

HELEN HAYES HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

Pulmonary Rehabilitation Participant Questionnaire Cont.

LEISURE ACTIVITIES My present interests/hobbies I can participate in are: _____

Former interests/hobbies I can no longer participate in are: _____

The following things limited my ability to remain active in the above: ☐ Fatigue ☐ Lightheadedness ☐ Shortness of Breath

☐ Joint problems (specify): _____ ☐ Other: _____

SOCIAL SUPPORT Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

I live with: ☐ Alone ☐ Spouse/Significant Other ☐ Family ☐ Other: _____

Forms of social interaction: ☐ Phone ☐ In person ☐ Religious services/organization

☐ Social clubs/Organizations ☐ Isolated

My major source(s) of support: (names and relationship) _____

_____

Emergency contact person: (Name, relationship, phone #) _____

TRANSPORTATION: ☐ Currently drive ☐ Rely on family ☐ Rely on friends ☐ Use public transportation

☐ Is a problem for me

PULMONARY HEALTH HISTORY: Cough: ☐ Yes ☐ No

If yes, do you usually cough up sputum and if so please describe (color, amount, consistency) _____

_____

Pulmonary infections approx. #/year: _____ Pulmonary hospitalizations # in past year: _____

I receive the flu vaccine annually: ☐ Yes ☐ No I have received the pneumonia vaccine: ☐ Yes ☐ No

OXYGEN: ☐ I do not have/use oxygen ☐ I have/use oxygen

Oxygen used: ☐ Continuously ☐ Only when I need it ☐ With sleep only ☐ With sleep and exercise

Oxygen system(s) I have: ☐ Stationary concentrator Flow rate (liters/min) _____

☐ Portable concentrator ☐ Tank/cylinder Flow rate (liters/min) _____ ☐ Continuous flow ☐ Pulsed flow

I change my oxygen tubing every: ☐ Week ☐ 2 Weeks ☐ 3-4 Weeks ☐ 1-2 Months

☐ Oops! I didn't know I needed to change it.

My home care oxygen equipment vendor is: _____

PERSONAL GOALS

My goals for completing pulmonary rehab are:

☐ To breathe better	☐ Improve weight/weight gain
☐ Learn to take my breathing medications correctly	☐ Help control panic/anxiety
☐ Increase my strength	☐ Take medications correctly
☐ Increase my endurance/stamina	☐ Stop smoking/Maintain tobacco cessation
☐ Be able to return to work	☐ Control panic/anxiety
☐ Be able to return to leisure/hobbies	☐ Regain confidence
☐ Improved psychological well being	☐ Learn how to do a safe and effective home exercise program
☐ Improved health related quality of life	☐ Symptom management
☐ Weight loss	☐ Other _____