First Name	Middle Name	Last Name

Medicare Number:	_ _ _ _ _ _ _ _ _ _	**Date of Birth:**	

Emergency / Next of Kin Name:		**Relationship:**	
Telephone 1		**Telephone 2**	

Respiratory Medications (Please list all Respiratory Medication You Use):	
Medication:	
Time of Last Dose:	

Medications - Please list all other medications (including herbal medicines) you are taking:

Past Medical History / Symptoms						
Have you been diagnosed with Asthma?						Yes / No
Have you been diagnosed with Chronic Obstructive Pulmonary Disease (COPD)?						Yes / No
Have you been diagnosed with any other lung diseases?						Yes / No
Have you been diagnosed with Obstructive Sleep Apnoea?						Yes / No
Have you been told you have a problem with your lungs?						Yes / No
Have you had a previous lung function test?	Yes / No	If YES, were the results normal?				Yes / No
Do you get short of breath? (please circle 1 option)	No	After any exertion	After severe exertion	On hills and stairs	Walking less than 100m	Walking more than 100m
Do you experience a wheeze? (please circle 1 option)	Constant	Frequent	Rare	No Wheeze		
Do you have a cough?	Yes / No	If Yes, is it:	productive (mucus excretions) or non-productive (dry)?			
Are you a smoker?	Yes / No	If yes, For how long have you smoked?				
		If yes, How many cigarettes per day do you smoke?				
Are you are an ex-smoker?	Yes / No	If Yes, when did you give up?				
		If yes, How many cigarettes per day were you smoking?				
Have you had any recent infections or illness?	Yes / No	If so, what was it?				

Height:	Weight:	BMI (Office Use):

Signature:		**Date:**	