EMPHYSEMA

CLIENT NAME: _____
Submit the Client Information Questionnaire with this form

1. What is the cause? Asthma, occupation, smoking?

2. What is the degree of severity?

3. Does client use oxygen?

4. Has client ever been hospitalized? If yes, give details.

5. Have pulmonary function tests been done?
   If so, what were the results?

6. Is client on medication? (accurate name, dosage, and reason)

7. Are there any restrictions of activities?

8. Are there any other health issues?

Please fax form to 612-392-7644 or email to mvp@mvpservicesolutions.com