

LUNG DISEASE

PRODUCER NAME: _____

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. Type of lung disease:
 Interstitial lung disease; type _____
 Chronic bronchitis
 Emphysema
 Asthma

2. List date when first diagnosed: _____

3. Was a biopsy done? yes no

4. Has client improved since diagnosis? yes no

5. Has client ever been hospitalized for this condition?
 yes; please give details _____
 no

6. Has client ever smoked?
 yes; currently smokes _____ (amount/day)
 yes; smoked in the past but quit _____ (date)
 never smoked

7. Have pulmonary function tests (breathing test) ever been done?
 yes; give most recent test results _____
 no

8. Does client have any abnormalities on an ECG or X-ray?
 yes; give details _____
 no

9. Is client on any medications (include inhalers, steroids)? (accurate name, dosage, and reason)

10. Does client have any other health issues? (additional questionnaires may be required)

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