

Follow Up Information

Today's Date: (d/m/y) _____ ID # _____ Initials _____

Date of Birth (d/m/y) _____ Height (cm) _____ Weight (kg) _____

 Have you changed your smoking habits in the **PAST YEAR**? Yes No

If yes, started smoking? Yes No

stopped smoking? Yes No Age at ceasing: _____

 If smoking, # cigarettes per day = _____, # cigars per day = _____, pipe
 smoking (g/week)= _____

Medical History (all questions refer to the **PAST YEAR !!!**)

Any new diagnosis? No Yes

 Lung Transplant? No Yes date: _____

Lung Volume Reduction? No Yes date: _____

Liver Transplant? No Yes date: _____

Pneumonia? No Yes # of times: _____

Have you had a CT of thorax in the past year? No Yes date: _____

 Have you had any chest infections in the last year that required treatment with
 prednisone and/or antibiotics? No Yes

If yes- tell us which month you received treatment and where the treatment was
 given:

Month	Year	Office	Emergency Room	Hospital

Present Treatment

Do you take medication for lung disease? No Yes

What are the medications called? _____

Are you on long term oxygen therapy (longer than 12 hours/day)? No Yes

Are you currently on Prolastin? No Yes

 Have you started Prolastin in past year? N/A No Yes Date: _____

Have you stopped Prolastin in past year? N/A No Yes Date: _____

Please provide a copy of your most recent pulmonary function test OR sign the attached permission form so that we can obtain it from your physician

Please provide a paper copy of any bloodwork results that you may have had to test your liver function.

Occupational Status

Are you presently working? Yes No

If no, is it due to (circle one)? lung disease age related other: _____

Completed By (please print): _____

Signature: _____

****Thank you for taking the time to complete this information! if you have any questions, please contact our toll-free number:**

1-800-352-8186: **