



## Primary Care Medical Center, PLLC

15444 Dedeaux Road, Suite B

Gulfport, MS 39503

Phone: (228) 832-9038 Fax: (228) 832-9990

Email: [info@primarycaregpt.com](mailto:info@primarycaregpt.com)

### **PULMONARY FUNCTION EXCLUSION QUESTIONNAIRE (PFT)**

PATIENT NAME	SSN	DATE

#### **IN THE PAST 3 MONTHS HAVE YOU HAD:**

MAJOR SURGERY (Chest, Abdominal, Mouth, Eye or Brain, requiring hospitalization?)

NO \_\_\_\_\_ YES \_\_\_\_\_

HEART ATTACK NO \_\_\_\_\_ YES \_\_\_\_\_

STROKE NO \_\_\_\_\_ YES \_\_\_\_\_

ANEURYSM OF THE BRAIN NO \_\_\_\_\_ YES \_\_\_\_\_

BP > 210/110 NO \_\_\_\_\_ YES \_\_\_\_\_

PNEUMOTHORAX NO \_\_\_\_\_ YES \_\_\_\_\_

DETACHED RETINA NO \_\_\_\_\_ YES \_\_\_\_\_

DO YOU CURRENTLY HAVE ANY LIMITATION ON PHYSICAL ACTIVITY PRESCRIBED BY YOUR DOCTOR?

NO \_\_\_\_\_ YES \_\_\_\_\_

#### **IN THE PAST YEAR:**

DID YOU OR ANYONE IN YOUR HOUSEHOLD HAVE TUBERCULOSIS?

NO \_\_\_\_\_ YES \_\_\_\_\_

IF THE PATIENT RESPONDS YES TO ANY OF THE ABOVE QUESTIONS, THE SPIROMETRY TEST SHOULD NOT BE COMPLETED. THE PROVIDER MUST BE NOTIFIED OF THE EXCLUSION RESPONSE. THE PROVIDER WILL DETERMINE IF THE SPIROMETRY TEST SHOULD CONTINUE.