

# Spirometry – Pre-Examination Questionnaire

Patients full name: .....

PESEL / Date of birth: ..... Age: .....

Adress: .....

**1. Have you recently experienced any long-term (>12 months) respiratory symptoms? If yes, please check which:**

- Not applicable
- Shortness of breath
- Dry cough
- Productive cough
- Wheezing

**2. Do you have any respiratory diseases?**

- Asthma
- Chronic bronchitisi
- COPD
- Frequent respiratory infections

**3. Do you have dental prostheses?**

- Yes
- No

**4. Do you smoke cigarettes?**

- Yes (how many per day?) .....
- No

**5. Do you use inhaled medications?**

- Yes (which?) .....

**6. Have you used inhaled medications today?**

- Yes (which?) .....
- No

**7. Are you pregnant? (For women only)?**

- Tak
- Nie

# Spirometria - ankieta przed badaniem

## 8. Please check if any of the following apply to you:

- Aortic or cerebral aneurysms
- Eye surgery (e.g., cataract, glaucoma, others)
- Increased intracranial pressure
- Retinal detachment
- Hemoptysis of unknown origin
- Pneumothorax
- Recent (within 6 weeks) myocardial infarction
- Recent (within 6 weeks) stroke of the central nervous system
- Surgeries involving ears, nose, or nasopharynx
- Recent surgeries involving the jaw or maxilla
- Nausea, vomiting, persistent cough, acute infection
- Postoperative pain in the abdominal or chest area that hinders full inhalation and exhalation during the test

## Nurse's Statement.

- No contraindications to performing the spirometry test were found.
- Contraindications to performing the spirometry test were found (specify):

.....  
(Signature and stamp of nurse)

.....  
(Location, date, time)

## I confirm the information is correct and I consent to the spirometry test.

.....  
(Date and Patient's signature)