# Comprehensive Occupational Medical Services

## *PULMONARY FUNCTION TEST REPORT*

Name: ____________________________________________ Date: _____________________

Employer: _____________________________________ SS#: __________________________

Sex: M / F Age: __________ Weight: __________ Height: __________ Race: _________

***SMOKING HISTORY***

Have you ever smoked? _____ Stopped _____ Years ago Years Smoked __________

Cigarettes (pks/day) _____ Cigars (day) _____ Pipe (oz.) _____

***RESPIRATORY HISTORY***

Dyspnea _________ Cough __________ Wheeze __________

Have you had a history of ASTHMA __________, BRONCHITIS __________,

COPD __________, EMPHYSEMA __________, ALLERGIES ________________________.

Have you had a respiratory infection (such as flu, pneumonia, bronchitis, or a chest cold in the last three weeks? YES NO

In the last 6 weeks have you had any major surgery or been hospitalized for an MI? YES NO

Have you used an inhaled bronchodilator in the last 6 hours? YES NO

Have you taken any bronchodilator pills in the last 6 hours? YES NO

Is a respirator ever recommended for breathing protection in your job? YES NO

Technician: _______________________

| VALUE BPTS | BEST | PREDICTED | % PREDICTED |
|---|---|---|---|
| FVC | | | |
| FEV1 | | | |
| FEV1 / FVC | | | |
| FEF $_{25-75}$ | | | |

*INTERPRETATION:*

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