1. Please describe your symptoms:
   - Shortness of breath
     - Yes
     - No
   - Chest pain / discomfort
     - Yes
     - No
   - Cough
     - Yes
     - No
   - Other (specify): ________________________________

   If you answered yes to symptoms please answer a) – c) Otherwise proceed to question 2.
   a. Details of shortness of breath
      - Recent onset
      - Recent worsening
      - At rest
      - With exertion walking on flat
      - With exertion running / climbing stairs
   b. Details of chest pain
      - Recent onset
      - Recent worsening
      - At rest
      - With breathing
      - With coughing
   c. Details of cough
      - Dry
      - Productive
      - Blood stained

2. Any recent prolonged period of bed rest or travel?  
   - Yes
   - No

3. Any recent leg or arm injury or surgery?  
   - Yes
   - No

4. Do you have lung disease? (Check all that apply)
   - Asthma
   - Chronic bronchitis or emphysema or COPD
   - Bronchiectasis
   - Lung cancer
   - Other (please specify) ________________________________
5. **Do you smoke?**
   - [ ] Yes  [ ] No
   - If yes, how many packs per day / week? ________________
   - How long have you smoked? ________________
   - If you recently quit, when was the last time you smoked? ________________

6. **Have you ever had a Pulmonary Embolus (PE)?**
   - [ ] Yes  [ ] No

7. **Have you ever had DVT (deep venous thrombus, clot in leg)?**
   - [ ] Yes  [ ] No

8. **Have you ever had any previous surgery to the lungs?**
   - [ ] Yes  [ ] No

9. **Have you ever had any prior history of cancer?**
   - [ ] Yes  [ ] No

10. **Have you ever had any prior history of blood clot problems?**
    - [ ] Yes  [ ] No

11. **Are you currently using any birth control pills?**
    - [ ] Yes  [ ] No

[Dose label #1 here]  [Dose label #2 here]

---

**NAME OF PATIENT (please print)**  
**SIGNATURE OF PATIENT**  
**DATE**  
**TIME**

**NAME OF STAFF (please print)**  
**SIGNATURE OF STAFF**  
**DATE**  
**TIME**