Seaway Valley
Community Health Centre
Working with you for a Healthier Community

LUNG HEALTH
SELF-REFERRAL FORM

Name: _____ DOB: _____

Phone: _____ Date: _____

Address: _____

Please circle YES or NO for the following questions:

Have you been diagnosed with a breathing problem? YES or NO
If you answered **yes** to the above question what was the diagnosis? _____

Do you take medications to help you with breathing? YES or NO

Have you ever had a breathing test? YES or NO

Do you smoke? YES or NO

Do you cough regularly? YES or NO

Do you cough up phlegm regularly? YES or No

Do you wheeze at night or when you exert yourself? YES or NO

Do you get frequent colds that last longer than other people's? YES or NO

What medications do you take: (please list below):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Internal Use Only

Triaged by: _____ Date of 1st appt: _____

May 2016