



PULMONARY FUNCTION TEST PATIENT FORM

Company Name: _____ Reason For Test: ☐ Initial Test ☐ Annual Test

First Name: _____ Last Name: _____

Phone: (____) ____ - _____ Email: _____

Date of Birth: ____/____/____ Height: ____ft ____in Weight: _____ pounds

Driver's license number _____

Please answer the following questions:

Yes No

- ☐ ☐ Do you have a cough that has lasted 3 weeks or more?
- ☐ ☐ Are you currently experiencing chest pain?
- ☐ ☐ Are you currently experiencing shortness of breath?
- ☐ ☐ Do you smoke cigarettes? If Yes: ____ cigarettes/day
- ☐ ☐ Do you vape or smoke any other products (cigars, clove, D8, etc.)
- ☐ ☐ Are you being treated for pulmonary issues (eg: asthma, COPD, emphysema)

If yes, what issues?: _____

Terms & Conditions

I consent to, and understand that, occupational health testing performed by Carolina Testing does not replace the interpretation of results and/or the care recommendations of a physician. I agree and willingly submit to testing requested on this form and authorize Carolina Drug & Alcohol Testing Services, LLC (Carolina Testing) to transmit and release the results of said testing to the current or prospective employer listed on this form. I understand that it is possible that the person or organization named to receive this information may re-disclose the information and if so, the information may no longer be protected by federal privacy rules.

_____/____/____

Patient Signature

Date

OFFICE USE ONLY

☐ PAID ☐ Cash ☐ Credit Card ☐ BILL TO ☐ TPA ☐ Company ☐ Insurance (lab work)

Billing Info: