Buteyko

Health Questionnaire

Buteyko Breathing Centre
PO Box 802, Whakatane New Zealand

Participant Details

First name: ____________________

Surname: ____________________

Address: ____________________

____

____

Post code: ____________________

Tel. home: ____________________

Tel. work: ____________________

Mobile: ____________________

Email: ____________________

DOB: ____________________

Male/Female: ____________________

Occupation: ____________________

Name of GP: ____________________

Surgery add.: ____________________

____

Surgery tel.: ____________________

Referred by: ____________________

Where did you hear about us?

____

Signature: ____________________

Date: ____________________
(if under 18 years of age, this form must be signed by a parent or guardian)

Have you had a sleep study? *Yes* *No*
Do you currently use a CPAP machine? *Yes* *No*
When did you commence CPAP therapy?

____

Have you previously used a CPAP? *Yes* *No*
If you answered *Yes*, why did you stop using CPAP?

____

____

Current Medication

Please tick the medication that you currently use or specify it if it is not listed. Please include medications for conditions other than asthma.

Puffers/Turbohalers

Medication	Dosage	am	pm
Becotide			
Becloforte			
Pulmicort			
Qvar			
Flixotide			
Intal			
Tilade			
Ventolin			
Salamol			
Bricanyl			
Respolin			
Atrovent			
Serevent			
Foradil			
Oxis			
Combivent			
Symbicort			
Seretide			

Other (please specify): ____________________

____

Nebulisers approximate minutes used ______

Medication	Dosage	am	pm
Ventolin			
Atrovent			
Bricanyl			
Intal			

Other (please specify):

____

____

Oral/Tablets

Medication	Dosage	am	pm
Nuelin			
Theodur			
Cortisone			
Prednisolone			
Singulair			
Accolate			
Intal			

Other (please specify):

____

____

Other medications (please specify):

Medication	Dosage	am	pm

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Please indicate where appropriate symptoms & severity using the following scale:
0 = Suffered in the past
1 = Mild
2 = Moderate
3 = Moderate to Severe
4 = Severe

- [ ] Arthritis
- [ ] Asthma
- [ ] Attention Deficit Disorder
- [ ] Anxiety / Panic Attacks
- [ ] Bronchitis
- [ ] Bronchiectasis
- [ ] Chronic Fatigue Syndrome
- [ ] Cystic Fibrosis
- [ ] Diabetes
- [ ] Emphysema
- [ ] Eczema
- [ ] Heart Condition
- [ ] High Blood Pressure
- [ ] Hypoglycaemia
- [ ] Low Blood Pressure
- [ ] Kidney Disease
- [ ] Migraine Headaches
- [ ] Multiple Sclerosis
- [ ] Cancer
- [ ] Schizophrenia
- [ ] Sleep Apnoea
- [ ] Stress
- [ ] Headaches
- [ ] Dizziness
- [ ] Insomnia
- [ ] Ringing or buzzing in the ears
- [ ] Loss of memory
- [ ] Mental fatigue
- [ ] Irritability
- [ ] Fear of sultry air
- [ ] Lack of concentration
- [ ] Loss of smell
- [ ] Fear without reason
- [ ] Apathy
- [ ] Coughing
- [ ] Loss of feeling in the limbs
- [ ] Impotence
- [ ] Dryness in the mouth
- [ ] Deterioration of vision
- [ ] Far sightedness
- [ ] Allergies
- [ ] Pains in the heart region
- [ ] Asthma attacks
- [ ] Painful & irregular menstruation
- [ ] Itching
- [ ] Muscle pains
- [ ] Dryness of skin
- [ ] Diarrhoea
- [ ] Shortness of breath
- [ ] Breathing through mouth
- [ ] Frequent deep breaths
- [ ] Breathing without pause after exhaling
- [ ] Tightness around chest
- [ ] Short temper
- [ ] Rhinitis
- [ ] Trembling & tic
- [ ] Deterioration of hearing
- [ ] Prone to colds and flu
- [ ] Flashes before the eyes
- [ ] Shuddering in sleep
- [ ] Sterility
- [ ] Frigidity
- [ ] Chest pains (not near heart)
- [ ] Weight gains
- [ ] Weight loss
- [ ] Bleeding veins
- [ ] Sudden chilling of limbs
- [ ] Varicose veins
- [ ] Sudden physical exhaustion
- [ ] Pains in the bones
- [ ] Anaemia
- [ ] Excessive mucous production
- [ ] Excessive sighing
- [ ] Excessive sneezing
- [ ] Excessive yawning
- [ ] Muscular spasms
- [ ] Palpitations
- [ ] Sinusitis
- [ ] Racing heart beat
- [ ] Loss of consciousness
- [ ] Tingling in the hands & fingers
- [ ] Difficulty in swallowing
- [ ] Constipation
- [ ] Haemorrhoids
- [ ] Abdominal bloating
- [ ] Snoring
- [ ] Depression
- [ ] Root canal therapy
- [ ] Nose bleeds
- [ ] Hay fever
- [ ] Swollen adenoids
- [ ] Gut disorders
- [ ] Ear infections/ glue ear

Other (please specify)

____
____
____

Medical History to Date (any other major illnesses/operations):

____
____
____
____

Which is your most severe health problem?

____
____

Age originally diagnosed: _____

How severe is your illness?
- [ ] Moderate
- [ ] Severe
- [ ] Very severe

Regularity of symptoms:

____

Please tick if you are pregnant:
- [ ]

Known allergies to drugs:

____
____