RESPIRATORY QUESTIONNAIRE

Patient Name: ______________________ Patient #: ______________

COUGH	YES	NO	Does Not Apply
1A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) (If **NO**, skip to question **1C.**)	☐	☐	*
B. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week?	☐	☐	*
C. Do you usually cough at all on getting up or first thing in the morning?	☐	☐	*
D. Do you usually cough at all during the rest of the day or at night?	☐	☐	*

IF YES TO ANY OF THE ABOVE (1A, 1B, 1C, OR 1D), ANSWER THE FOLLOWING:
IF NO TO ALL. CHECK *"DOES NOT APPLY"* AND SKIP TO QUESTION 3A.

	YES	NO	Does Not Apply
E. Do you usually cough like this on most days for 3 consecutive months or more during the year?	☐	☐	☐
F. For how many years have you had the cough? Number of years:	______		☐

PHLEGM PRODUCTION

	YES	NO	Does Not Apply
2A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If **NO**, skip to **2C.**)	☐	☐	*
B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?	☐	☐	*
C. Do you usually bring up phlegm at all on getting up or first thing in the morning?	☐	☐	*
D. Do you usually bring up phlegm at all during the rest of the day or at night?	☐	☐	*

IF YES TO ANY OF THE ABOVE (2A, 2B, 2C, OR 2D), ANSWER THE FOLLOWING:
IF NO TO ALL. CHECK *"DOES NOT APPLY"* AND SKIP TO QUESTION 3A.

	YES	NO	Does Not Apply
E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?	☐	☐	☐
F. For how many years have you had trouble with phlegm? Number of years:	______		☐

EPISODES OF COUGH AND PHLEGM

	YES	NO	Does Not Apply
3A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year? *(For persons who usually have cough and/or phlegm)	☐	☐	*

IF YES TO 3A

	YES	NO	Does Not Apply
B. For how long have you had at least 1 such episode per year? Number of years:	______		☐

WHEEZING

4A. Does your chest ever sound wheezy or whistling . . .

	YES	NO	Does Not Apply
1. When you have cold?	☐	☐	*
2. Occasionally apart from colds?	☐	☐	*
3. Most days or nights?	☐	☐	*

IF YES TO 1, 2, OR 3 IN 4A

	YES	NO	Does Not Apply
B. For how many years has this been present? Number of years:	______		☐
5A. Have you ever had an attack of wheezing that has made you feet short of breath?	☐	☐	*

	YES	NO	Does Not Apply
IF YES TO 5A			
B. How old were you when you had your first suchattack? . . . . Age in years:	______		☐
C. Have you had 2 or more such episodes?	☐	☐	☐
D. Have you ever required medicine or treatment for the(se) attacks?	☐	☐	☐

BREATHLESSNESS

6. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to **Question 8A.**

____

____

____

____

	YES	NO	Does Not Apply
7A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?	☐	☐	*
IF YES TO 7A			
B. Do you have to walk slower than people of your age on the level because of breathlessness?	☐	☐	☐
C. Do you ever have to stop for breath when walking at your own pace on the level?	☐	☐	☐
D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?	☐	☐	☐
E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs? . . .	☐	☐	☐

CHEST COLDS AND CHEST ILLNESSES

	YES	NO	Does Not Apply
8A. If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)	☐	☐	*
9A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?	☐	☐	*
IF YES TO 9A			
B. Did you produce phlegm with any of these chest illnesses?	☐	☐	☐
C. In the last 3 years, how many such illnesses with (increased phlegm) did you have which lasted a week or more? . . . . Number of illnesses:	______		☐
10. Did you have any lung trouble before the age of 16?	☐	☐	*
11. Have you ever had any of the following:			
1A. ATTACKS OF BRONCHITIS?	☐	☐	*
IF YES TO 1A			
1B. Was it confirmed by a doctor?	☐	☐	*
1C. At what age was your first attack? . . . . Age in years:	______		☐
2A. PNEUMONIA (INCLUDE BRONCHOPNEUMONIA)?	☐	☐	*
IF YES TO 2A			
2B. Was it confirmed by a doctor?	☐	☐	*
2C. At what age did you first have it? . . . . Age in years:	______		☐

	YES	NO	* Does Not Apply
3A. HAY FEVER?	☐	☐	*
IF YES TO 3A			
3B. Was it confirmed by a doctor?	☐	☐	*
3C. At what age did it start? Age in years: ______			☐

CHRONIC BRONCHITIS

	YES	NO	* Does Not Apply
12A. Have you ever had chronic bronchitis?	☐	☐	*
B. Do you still have it?	☐	☐	☐
C. Was it confirmed by a doctor?	☐	☐	☐
D. At what age did it start? Age in years: ______			☐

EMPHYSEMA

	YES	NO	* Does Not Apply
13A. Have you ever had emphysema?	☐	☐	*
IF YES TO 13A			
B. Do you still have it?	☐	☐	☐
C. Was it confirmed by a doctor?	☐	☐	☐
D. At what age did it start? Age in years: ______			☐

ASTHMA

	YES	NO	* Does Not Apply
14A. Have you ever had asthma?	☐	☐	☐
IF YES TO 14A			
B. Do you still have it?	☐	☐	☐
C. Was it confirmed by a doctor?	☐	☐	☐
D. At what age did it start? Age in years: ______			☐
E. If you no longer have it, at what age did it stopped? Age stop: ______			☐

OTHER

15. Have you ever had:

	YES	NO	* Does Not Apply
A. Any other **CHEST ILLNESS**? If yes, please specify:	☐	☐	*
B. Any **CHEST OPERATIONS**? If yes, please specify:	☐	☐	*
C. Any **CHEST INJURIES**? If yes, please specify:	☐	☐	*

	YES	NO	* Does Not Apply
16A. Has a doctor ever told you that you had **HEART TROUBLE**?	☐	☐	*

IF YES TO 16A

	YES	NO	Does Not Apply
B. Have you ever had treatment for heart trouble in the past 10 years?	☐	☐	☐
17A. Has a doctor ever told you that you had **HIGH BLOOD PRESSURE**?	☐	☐	*

IF YES TO 17A

	YES	NO	Does Not Apply
B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?	☐	☐	☐

18. When did you last have your **CHEST X-RAY**? Year: ______

19. Where did you last have your chest x-ray (if known)? ______

    What was the outcome? ______

FAMILY HISTORY

20. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	FATHER			MOTHER		
	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
A. CHRONIC BRONCHITIS						
B. EMPHYSEMA						
C. ASTHMA						
D. LUNG CANCER						
E. OTHER CHEST CONDITIONS						
F. IS PARENT CURRENTLY ALIVE						
G. PLEASE SPECIFY AGE	AGE IF LIVING					
	AGE AT DEATH					
	DON'T KNOW					

TOBACCO SMOKING

	YES	NO	Does Not Apply
21A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)	☐	☐	*

IF YES TO 21A

	YES	NO	Does Not Apply
B. Do you now smoke cigarettes (as of one month ago)?	☐	☐	☐
C. How old were you when you first started regular cigarette smoking? Age in years:	______		☐
D. If you have stopped smoking cigarettes completely, how old were you when you stopped? Age in years:	______		☐
Check if still smoking:	☐	*	*
E. How many cigarettes do you smoke per day now? Cigarettes per day:	______		☐

	YES	NO	Does Not Apply
F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?			
Cigarettes per day:	______		☐
G. Do or did you inhale the cigarette smoke? Not at all:	☐	*	☐
Slightly:	☐	*	☐
Moderately:	☐	*	☐
Deeply:	☐	*	☐
22A. Have you ever smoked a pipe regularly? (Yes means more than 12 oz. of tobacco in a lifetime)	☐	☐	*
IF YES TO 22A FOR PERSONS WHO HAVE EVER SMOKED A PIPE			
B. 1. How old were you when you started to smoke a pipe regularly? Age in years:	______		☐
2. If you have stopped smoking a pipe stopped completely, how old were you when you stopped?	______		☐
Age in years:	______		☐
Check if still smoking pipe:	☐	*	*
C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week? (a standard pouch tobacco contains 1 1/2 oz.) oz. per week:	______		☐
D. How much pipe tobacco are you smoking now? oz. per week:	______		☐
E. Do you or did you inhale the pipe smoke? Not at all:	☐	*	☐
Slightly:	☐	*	☐
Moderately:	☐	*	☐
Deeply:	☐	*	☐
23A. Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year)	☐	☐	*
IF YES TO 23A FOR PERSONS WHO HAVE EVER SMOKED CIGARS			
B. 1. How old were you when you started smoking cigars regularly? Age in years:	______		☐
2. If you stopped smoking cigars completely, how old were you when you stopped? Age in years:	______		☐
Check if still smoking pipe:	☐	*	*
C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?			
Cigars per week:	______		☐
D. How many cigars are you smoking per week now? Cigars per week:	______		☐
Check if not smoking cigars currently:	☐	*	*
E. Do or did you inhale the cigar smoke? Not at all:	☐	*	☐
Slightly:	☐	*	☐
Moderately:	☐	*	☐
Deeply:	☐	*	☐

ADDITIONAL QUESTIONS

	YES	NO	Does Not Apply
Do you wear contact lenses when at work?	☐	☐	*
Have you ever been told that you have a hole in your eardrum?	☐	☐	*
Have you ever suffered from claustrophobia (being afraid of being in small, closed spaces)?	☐	☐	*

Signature: ______________________________ Date: ________________