Respiratory Questionnaire

Name   Date

> INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints.
> Leave the question blank if it does not apply to you.
> 0 = RARELY OR NEVER EXPERIENCE SYMPTOM   1 = MILD   2 = MODERATE   3 = SEVERE

PART 1: Respiratory Function

Section A:

#		
1	Chronic cough	0 1 2 3
2	Breathing difficulties	0 1 2 3
3	Chest pains	0 1 2 3
4	Wheezing	0 1 2 3
5	Hypersensitive to environmental pollutants	0 1 2 3
6	Excessive mucous in throat and nose	0 1 2 3
7	Frequent sore throats	0 1 2 3
8	Work around chemicals/pollutants/radiation	0 1 2 3
9	Chronic pain around ribcage	0 1 2 3
10	Bluish color to lips and nails	0 1 2 3
11	Post nasal drip	0 1 2 3
12	Smoker (Press 0 for NO, 1 for YES)	NO YES
13	Cough up blood (Press 0 for NO, 1 for YES)	NO YES
14	Current bronchial/lung infection (Press 0 for NO, 1 for YES)	NO YES
15	Diagnosed with asthma (Press 0 for NO, 1 for YES)	NO YES
16	History of bronchitis (Press 0 for NO, 1 for YES)	NO YES
17	Recurrent sinus infections (Press 0 for NO, 1 for YES)	NO YES
18	Most infections settle in your lungs (Press 0 for NO, 1 for YES)	NO YES