

Appendix 1. Respiratory questionnaire.

Respiratory Questionnaire

Name: _____ **Date:** ____/____/____

Chart number: _____ **Age:** _____ **Date of birth:** ____/____/____ **Gender:** M () F ()

() Telephone number: () _____

Reason for examination: _____

1 – SMOKING:

Do you smoke or have you ever smoked cigarettes? Yes () No ()

When did you smoke your last cigarette? _____.

How old were you when you started smoking regularly? _____ years old.

In case you have quit smoking completely, when did you quit? _____ ago.

Ever since you started smoking, how many cigarettes have you smoked per day? _____.

(Leave blank)-Calculation of pack-years _____

2 – SYMPTOMS:

Have you coughed more in the past few years? Yes () No ()

Do you usually cough or clear your throat in the morning? Yes () No ()

Do you usually cough up phlegm? Yes () No ()

On average, how much phlegm do you cough up on most days: no phlegm or less than one tablespoon of phlegm per day () one or more tablespoons of phlegm per day (....)

Do you often wheeze? Yes () No ()

Have you ever had two or more wheezing attacks relieved by inhaled medication use? Yes () No ()

Does wheezing improve with the use of any medication in particular? Yes () No ()

When was the last time that you used a bronchodilator? _____.

• You experience shortness of breath:

Have you experienced more shortness of breath in the past few years? Yes () No ()

Grade 0 (Expected) – During extraordinary activities, such as running and carrying heavy loads on level ground or light loads while climbing stairs? Yes () No ()

Grade 1 (Mild) – During major activities, such as walking up a steep incline, going up two or more floors, and carrying heavy shopping bags on level ground? Yes () No ()

Grade 2 (Moderate) – During moderate activities, such as going up one floor, walking rapidly on ground level, and carrying light loads on ground level? Yes () No ()

Grade 3 (Severe) – During light activities, such as bathing or walking one block at a steady pace? Yes () No ()

Grade 4 (Very severe) – At rest, getting dressed, or walking a few steps at a slow pace? Yes () No ()

• Lung diseases:

Have you ever had any lung diseases? Yes () No ()

Which? _____.

Do you have or have you ever had asthma or bronchitis? Yes () No ()

Do you currently take any medication for asthma or bronchitis? Yes () No ()

Which? _____.

Have you ever undergone chest or lung surgery? Yes () No ()

Have you ever been on mechanical ventilation? Yes () No ()

• Other diseases:

Heart diseases? Yes () No () Which? _____.

Do you have pulmonary arterial hypertension? Yes () No ()

Other diseases with lung involvement? Yes () No ()

• Work history:

Have you ever worked in a dusty place for one year or more? Yes () No ()

If yes, specify your job activities: _____.