

Form Approved:
OMB No. 0920-XXX
Exp. Date: _____

Health Questionnaire for study “Aerosol Generation by Cough”

Record Number:

Age: Gender: M F Height: Weight:

(Note: If the participant answers “yes” to any of these questions, they should not participate in the study)

Have you ever been a smoker?	YES	NO
If female, are you pregnant?	YES	NO
If female, was your last menstrual period more than 8 weeks ago?	YES	NO
Were you vaccinated against the flu in the past 6 months?	YES	NO
Do you have any respiratory illness such as asthma, COPD or tuberculosis?	YES	NO
Besides the flu, do you have any other illnesses such as diabetes or heart disease?	YES	NO
Are you in good health overall?	YES	NO
During this study, you will be asked to inhale deeply and cough hard several times. Do you have any condition or illness that would make it difficult or uncomfortable for you to do this?	YES	NO

Oral temperature:

Do you have any of the following symptoms? (Circle all that apply)

Headache Fatigue Cough Sore throat Muscle aches

Results from influenza test: Positive Negative Invalid

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