Attachment 5: Health Questionnaire

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

Health Questionnaire for study "Aerosol Generation by Cough"

Record Number:

Age:

Sex:

Height:

Weight:

Smoking History: ______Current ______Former ______Never
Average number of cigarettes per day _________
Age started __________ Age quit __________

Do you have any of the following conditions?			If YES, did a doctor tell you that you had this condition?		Do you take any medication for this problem?	
Asthma	YES	NO	YES	NO	YES	NO
Emphysema	YES	NO	YES	NO	YES	NO
Frequent cough	YES	NO	YES	NO	YES	NO
Allergies	YES	NO	YES	NO	YES	NO
Chronic obstructive pulmonary disease (COPD)	YES	NO	YES	NO	YES	NO
Other Respiratory Illness (specify)	YES	NO	YES	NO	YES	NO

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