Attachment 4:
Health Questionnaire

Name: _____ Record Number: **FC**_____

Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/20xx

Age: Gender: M F Height: Weight:

1. Do you have any respiratory illness such as severe asthma, COPD or tuberculosis?	YES	NO
2. Besides the flu, do you have any other illnesses such as diabetes or heart disease?	YES	NO
3. 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
4. If female, are you pregnant?	YES	NO

(Note: If the participant answers **"yes"** to any of the questions **1-4**, they should not participate in the study)

5. Do you have any of the following symptoms? (Circle all that apply) Fever/chills Headache Fatigue Cough Sore throat Muscle aches Sinus congestion Runny nose If YES, when did your symptoms begin?		
6. Were you vaccinated against the flu in the past 6 months? YES NO		
7. Are you currently a smoker (including occasional/recreational)? If YES, how often do you smoke? If NO, have you smoked in the past? How long ago and how often?	YES YES	NO NO

Oral temperature (°C)
Results from rapid influenza test Positive A Positive B Negative Invalid

	Cough 1	Cough 2	Cough 3
Sampler #			
FVC			
PEF			