## Attachment 4: Health Questionnaire

Name:	Record Number: <b>FC</b>

Age: Gender: M F Height: Weight:

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 conge	estion	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)? YES NO					NO	
If YES, how often do you smoke?						
If NO, have you smoked in the past? How long ago and how often?				YES	NO	

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

	Cough 1	Cough 2	Cough 3
Sampler #			
FVC			
PEF			

Public reporting burden of this collection of information is estimated to average XX minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxxx).