RESPIRATORY QUESTIONNAIRE

ADMINISTRATIVE INFORMATION
0a. Completion Date:__/__/____ 0b. Staff ID: _______ _______

BREATHELESSNESS
1. Are you disabled from walking by any condition other than heart or lung disease?
   Yes...............................
   No...............................  

2. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?
   Yes...............................
   No...............................  

3. Do you have to walk slower than people of your age on level ground because of breathlessness?
   Yes...............................
   No...............................  

4. Do you ever have to stop for breath when walking at your own pace on level ground?
   Yes...............................
   No...............................  

5. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on level ground?
   Yes...............................
   No...............................  

6. Are you too breathless to leave the house or breathless on dressing or undressing?
   Yes...............................
   No...............................  

7. Have you ever had to sleep on 2 or more pillows to help you breathe?
   Yes...............................
   No...............................  

8. Have you ever been awakened at night by trouble breathing?
   Yes...............................
   No...............................  

CONDITIONS
9. Has a doctor ever told you that you had emphysema or chronic obstructive pulmonary disease (also called COPD)?
   Yes...............................
   No...............................  →Go to Item 10
9a. How old were you when the doctor first told you this? ..............................................

9b. Do you still have it?
   Yes...........................................
   No...........................................

10. Has a doctor ever told you that you had chronic bronchitis?
   Yes...........................................
   No...........................................
   → Go to Item 11

10a. How old were you when the doctor first told you this? ..............................................

10b. Do you still have it?
   Yes...........................................
   No...........................................

11. Did you have breathing problems as a child (before age 16)?
   Yes...........................................
   No...........................................

12. Have you ever had asthma?
   Yes...........................................
   No...........................................
   → Go to Item 13

12a. Was it confirmed by a doctor?
   Yes...........................................
   No...........................................

12b. At what age did it start? ........................................................................................................

12c. Do you still have it?
   Yes...........................................
   No...........................................
   → Go to Item 13

12d. At what age did it stop? ........................................................................................................

13. Do you have allergies that trigger asthma symptoms?
   Yes...........................................
   No...........................................

SLEEP

14. Does someone else usually sleep in the same room as you?
   Yes...........................................
   No.............................................
15. How often do you snore now? .............................................................. A
   Never ................................................................. A
   Rarely (1-2 nights a week) ........................................ B
   Sometimes (3-5 nights a week) ............................. C
   Always or almost always (6-7 nights a week) ...... D
   Other (note log)....................................................... E

16. How often do you have times when you stop breathing during your sleep? .............................................................. A
   Never ................................................................. A
   Rarely (1-2 nights a week) ........................................ B
   Sometimes (3-5 nights a week) ............................. C
   Always or almost always (6-7 nights a week) ...... D
   Other (note log)....................................................... E

17. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)
   □□ Hours of sleep per night

18. Overall, was your typical night’s sleep during the past 4 weeks ........... A
   Very sound or very restful ........................................ A
   Sound or restful ..................................................... B
   Average quality ................................................... C
   Restless ............................................................... D
   Very restless ......................................................... E
   Other (note log)....................................................... F

19. Have you ever been told by a doctor that you have sleep apnea?
   Yes ........................................
   No ........................................ → Go to END

19a. How old were you when you were first diagnosed with sleep apnea? ......... □□

19b. Have you had any treatment for sleep apnea?
   Yes ........................................
   No ........................................ → Go to END

What type of treatment did you receive for sleep apnea?

19b1. CPAP .............................................................. Yes □ No □
19b2. BILEVEL .......................................................... □ □
19b3. Oral device ........................................................... □ □
19b4. Surgery .............................................................. □ □
19b5. Other .............................................................. □ □

19b5a. If other, specify: _______________________________________________