RESPIRATORY QUESTIONNAIRE

ID NUMBER: | | | | | | | | FORM CODE: R S X DATE: 03/22/2024 Version 2.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

BREATHLESSNESS

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 ..... ☐ → **Go to Item 13**
No ..... ☐

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? ☐

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? ☐

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 ..... ☐

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?

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

19b5a. If other, specify: _____