CENTER FOR COUGH
MANDEL SHER, M.D.

Cough Questionnaire

Patient's Name: ________________________________ Date of Birth: ____________________.

INSTRUCTIONS: **Please answer the questions as complete and accurately as possible. All information is important in learning about your chronic cough problem. Please bring this completed form to your first appointment.**

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COUGH: Date of onset (how long has cough been present):______________________

Did you have an upper respiratory infection at onset of cough (virus, flu or cold)? yes no

Has cough been: episodic (off & on)__________ or continuous________________

Activity or situations affecting cough:

Graded severity as: 0-not present 1-mild 2-moderate 3-severe or frequent

Upon waking up ______ During day______ Lying down_______ Middle of night______

Talking______ After meals______ During or after exercise_______ Laughter_____

Character of cough: 0-not present 1-mild 2-moderate 3-severe or frequent

Frequency ________ Dry___________ Hack/bark___________ Wet__________

If wet cough please describe:

Produce mucous/ sputum ____________ Color______________ Amount_______

NASAL SYMPTOMS (RHINITIS):

Graded severity as: 0-not present 1-mild 2-moderate 3-severe or frequent

Nasal congestion_____ post nasal drip____ (if yes – color________) runny nose_____

throat clearing____ Sore throat_____ hoarseness____ sneezing____ nasal itching____

bloody nose_____ decreased smell/taste_____ headaches_____ sinus pressure______

Symptoms present Year round_____ or seasonal (which ones) __________________

Have you had diagnosis of sinusitis? (dates and treatment):______________________

____

Precipitating triggers: check any factors that can trigger or affect your condition

Trees_____ Grass____ Mold____ Dust_____ Outdoor exposure_____ Cat_____

Dog_____ Odors (perfumes)_____ Auto fumes_____ Smoking exposure______

Eating______ Cleaning agents_______ Other____________________________

Previous Tests : (please give dates and results):

Allergy blood or skin test: ____

Sinus x-rays or CT Scan: ____

Rhinitis treatment/medications: (please list medication and length of treatment)

Nasal steroids____

Nasal and/or Oral antihistamines_______________________________________

Oral decongestants____

Oral steroids____

Allergy immunotherapy (shots) ____

Other ____

GERD :Do you have any of following symptoms?

Heartburn_____ Indigestion_____ Regurgitation of food_____ Bad taste in throat______

Difficulty/painful swallowing____ Hoarseness____ Sore throat____ Throat clearing _____

Do you frequently eat or drink: (Y or N)

Caffeine_____ Chocolate_____ Carbonated beverages_____ Orange/citrus______

Tomatoes_____ Spicy food_____ Fried/fatty foods_____ Snack before bed_____

Alcohol______ Mints______

Previous Tests : (please give dates)

Endoscopy ____________ pH probe______________ other tests___________________

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Treatment: Antacid medicine (please list medication and length of treatment)

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____

Diet control or restrictions:____

____

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ASTHMA RELATED SYMPTOMS:

Have you been diagnosed with asthma?_________ When?_______________________

Do you: Cough with exercise?______________ Cough with laughter?____________

Wake up during night with cough?____

Do you have :

Wheezing?________ chest tightness?________ shortness of breath?_____________

Are symptoms triggered by:

Upper respiratory infections___________ cold air__________ Exercise____________

Exercise in cold air______ Allergy triggers (if yes which ones) _____________________

____

Other triggers: ____

____

Previous Tests : (please give dates and results):

Chest x-rays:____

Lung functions testing:____

Chest CT Scan:____

Other:____

Asthma treatment/medications: (please list medication and length of treatment)

Inhaled steroids__________________________ Inhaled albuterol_________________

Oral steroids_________________________ Other inhalers_________________________

Singulair_________________ Other Therapy___________________________________

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