CENTER FOR COUGH

MANDEL SHER, M.D.

Cough Questionnaire

PLEASE DO NOT PLACE YOUR NAME OR DATE OF BIRTH ON THIS FORM

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.**

OFFICE USE ONLY

1.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 _____

2.NASAL SYMPTOMS (RHINITIS):

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

Nasal congestion _____ Postnasal drip _____ (if yes-color____) Runny rose_____

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): _____

_____

3. 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: _____

4. 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 _____

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5. GERD: Do you have any of the 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 _____

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

_____

_____

Diet control or restrictions:

_____

_____

6. ASTHMA RELATED SYMPTOMS:

Have you been diagnosed with asthma? _____ When? _____

Do you: Cough with exercise? _____ Cough with laughter? _____

Wake up coughing during the night _____

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 _____

_____

7. DRUG/MEDICATION/IMMUNIZATION ALLERGIES & INTOLERANCES:

List all drug allergies and the reactions (hives, rash, nausea, vomiting, diarrhea, difficulty breathing, etc.)

1._____ 4._____

2._____ 5._____

3._____ 6._____

8. MEDICATIONS (INCLUDING OVER-THE-COUNTER):

MEDICATION NAME	STRENGTH	DAILY FREQUENCY	MEDICATION NAME	STRENGTH	DAILY FREQUENCY

9. MEDICAL HISTORY: HAVE YOU HAD OR BEEN DIAGNOSED WITH (CHECK ALL THAT APPLY)?

○ Anemia	○ Diabetes Type 1 or Type 2:	○ Irritable bowel syndrome	○ Osteopenia/ Osteoporosis
○ Anxiety	○ Fibromyalgia	○ Jaundice / liver disease	○ Pneumonia/ Lung disease
○ Arthritis Osteo or Rheumatoid	○ Glaucoma	○ Kidney disease	○ Prostate problems
○ Atrial fibrillation	○ GERD/heartburn	○ Low back pain	○ Seizures/Epilepsy
○ Bleeding disorder	○ Heart attack	○ Migraines / Headaches	○ Sleep Apnea
○ Cancer What kind?	○ Heart disease	○ Menopause	○ Sleep Disturbance
○ Cataracts	○ Heart failure	○ Menstrual Irregularities	○ Thyroid Disease
○ Colon polyps	○ High blood Pressure / hypertension	○ Neuropathy	○ Ulcers
○ Depression	○ High cholesterol	○ Obesity	○ Urinary incontinence
Other:			

10. HEALTH MAINTENANCE (LIST IF/WHEN LAST PERFORMED):

- Bone density test: _____
- Colonoscopy: _____
- Endoscopy: _____
- Flu vaccine: _____
- Meningococcal Vaccine: _____

MMR Vaccine: _____
Pneumonia: _____
Shingles Vaccine: _____
Tetanus Vaccine: _____

11. SURGICAL HISTORY (List any surgeries or procedures you have had performed):

WHAT	DATE	WHAT	DATE

12. HOSPITALIZATIONS (List ANY hospitalizations):			
WHY?	DATE	WHAT	DATE

13. FAMILY HISTORY: Please indicate if your blood relative(s) have had/currently have the following

Family Member	Alive	Deceased	Year of birth/Age	Asthma	Allergic Rhinitis/Hay fever	Food Allergy	Drug Allergy	Diabetes	Hypertension/ High blood pressure	Heart disease	Mental illness	Unknown history
Mother												
Father												
Sons(s)												
Daughter(s)												
Sibling(s)												

Other (Please specify):

14. Review of Systems. Please circle all that apply.

Fatigue	Diarrhea	Weakness	Irregular Heartbeat
Fever	Vomiting	Fainting	Abdominal Pain
Disordered Sleep	Bruising	Anxiety	Joint Pain
Weight Changes	Bleeding	Depression	Constipation
Muscle Pain	Urinary Urgency	Urinary Frequency	

15. BIRTH HISTORY: Please complete the following for dependent children under 18 years of age.

Place of Birth:_____. Age of mother at birth:_____

Was pregnancy normal: Yes / No If no, please specify reason: _____

_____.

Was delivery by: C-Section / Vaginal Patient was: Formula fed / Breast fed

In the first year of life were any of the following present? Colic / Spit up a lot / Rash / Eczema

Was patient born with pets present in the home? Yes / No (If yes, please list):_____

16. MARITAL STATUS: Married / Single / Widowed / Separated / Divorced Number of children: ___

17. RESIDENCE: List your past residences with your most recent first. List only city and state.

	City & State	How Long	Symptoms better	Symptoms Worse	No Change
1.					
2.					
3.					

18. WORK ENVIRONMENT:

What type of work do you do? _____ Where are you employed? _____

Is your work environment: Carpeted / Tiled Are you exposed to chemicals or strong odors or anything that might aggravate your condition

If yes, please specify: _____

19. SCHOOL ENVIRONMENT:

What school do you attend? _____

What Grade? _____

Have you missed school because of your allergies? _____ How many days in the last year? _____

Do you feel extra-curricular activities have been affected by allergies?

_____

_____

20. ENVIRONMENTAL SURVEY:

Approximate age of house:	How old is your _____ pillow? _____ Mattress?
Are any rooms damp or musty?	Is your pillow: Feather / Foam rubber / Dacron / Encased in plastic / other
Type of heating? (electric, gas, central, etc)	Is your mattress: innerspring / foam rubber / waterbed / encased in plastic / other.
Do you have: Air cleaner / Air dehumidifier	Are your sheets washed in: cold / warm / hot water
How often do you change/clean your air conditioner and air cleaner filters?	Do you have any: Stuffed animals / Feather comforters / Stuffed furniture
Is the home: carpeted / tiled Is bedroom: carpeted / tiled	Other:

Please circle yes or no:

Have you ever smoked? Yes / No If yes, how many years? _____

Do you presetly smoke? Yes / No

If no, when did you stop? _____.

Average cigarettes per day at highest point? _____

If you still smoke, do you think you could stop? Yes / No

Do you or family members smoke: In the house? _____ In the car? _____

Which other family members now smoke?

_____

Do you drink alcohol? Yes / No

If yes, list _____

Average weekly consumption (times per week): _____

Do you consume caffeine? Yes / No

If yes, how many caffeine drinks do you consume per day? _____

Do you use drugs other than for medical reasons? Yes / No

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LEICESTER COUGH QUESTIONNAIRE

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This questionnaire is designed to assess the impact of cough on various aspects of your life. Read each question carefully and answer with the best response that applies to you. Please answer ALL questions as honestly as you can.

1=all the time 2=most of the time 3=a good bit of the time 4=some of the time 5=a little bit of the time 6=hardly any of the time 7=none of the time	
1. In the last 2 weeks, have you had chest or stomach pains as a result of your cough?	
2. In the last 2 weeks, have you been bothered by sputum (phlegm) production when you cough?	
3. In the last 2 weeks, have you been tired because of your cough?	
4. How often during the last 2 weeks, have you felt embarrassed by your coughing?	
5. In the last 2 weeks, my cough has made me feel anxious	
6. In the last 2 weeks, my cough has interfered with my job	
7. In the last 2 weeks, I felt my cough interfered with the overall enjoyment of my life	
8. In the last 2 weeks, exposure to paint or fumes has made me cough	
9. In the last 2 weeks, has your cough disturbed your sleep	
10. In the last 2 weeks, how many times a day have you had a coughing bout?	
11. In the last 2 weeks, my cough has made me feel frustrated	
12. In the last 2 weeks, my cough has made me feel fed up	
13. In the last 2 weeks, have you suffered from a hoarse voice as a result of your cough	
14. in the last 2 weeks, have you worried that your cough may indicate serious illness	
15. In the last 2 weeks, have you been concerned that other people think something is wrong with you, because of your cough?	
16. In the last 2 weeks, my cough has interrupted conversation or telephone calls	
17. In the last 2 weeks, I feel that my cough has annoyed my partner, family, or friends	

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18. In the last 2 weeks, have you felt in control of your cough	
19. In the last 2 weeks, have you had a lot of energy	

FOR OFFICE USE

(1,2,3,9,10,11,14,15)= PH _____/ 8 = _____ (1-7)

(4,5,6,12,13,16,17)= PS _____/ 7 = _____ (1-7) > Total Score _____ (3-21)

(7,8,18,19)= SO _____/ 4 = _____ (1-7)