

Appendix 5

Adult Questionnaire (ATS-DLD-78-A)

Children's Questionnaire (ATS-DLD-78-C)

Adult Questionnaire

NAME: _____
(Last) (First) (Middle Initial)

ADDRESS: _____
(Street or Route No.)

(City) (County) (Zip Code)

TELEPHONE NUMBER: _____
(Area Code)

INTERVIEWER (if applicable) _____

DATE QUESTIONNAIRE COMPLETED: _____

1. Date of Birth: _____
Month Day Year

2. Place of Birth: _____

3. Sex: 1. Male ___
2. Female ___

4. What is your marital status? 1. Single ___
2. Married ___
3. Widowed ___
4. Separated/Divorced ___

5. Race: 1. White ___
2. Black ___
3. Oriental ___
4. Native American ___
5. Mexican-American ___
6. Other ___ Specify _____

6. Circle the highest grade completed in school.
1. Grade School or Junior High: 1 2 3 4 5 6 7 8
2. High School: 9 10 11 12
3. Post High School-Technical School: 1 2
4. College: 1 2 3 4 Bachelor's Degree Advanced Degree

These questions pertain mainly to your chest. Please answer *yes* or *no* if possible. If a question does not appear to be applicable to you, check the *does not apply* space. If you are in doubt about whether your answer is *yes* or *no*, record *no*.

COUGH

- 7A. Do you usually have a cough? (Count a cough with first smoke or on first going out-of-doors. Exclude clearing of throat.) 1. Yes ___ 2. No ___
- B. Do you usually cough at all on getting up, or first thing in the morning? 1. Yes ___ 2. No ___

IF YES TO ANY OF ABOVE (7A or B), ANSWER THE FOLLOWING:
IF NO TO ALL, CHECK *DOES NOT APPLY* AND SKIP TO NEXT SECTION.

- C. Do you usually cough like this on most days for 3 consecutive months or more during the year? 1. Yes ___ 2. No ___
8. Does not apply _____
- D. For how many years have you had this cough? _____
Number of years
88. Does not apply _____

- 7E. During which months does your cough give you the most trouble? (Check months troubled) OR: Check here if no relation to time of year_____. 8. Does not apply _____
- | | | | | | | | | | | | |
|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |

PHLEGM

- 8A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out-of-doors. Exclude phlegm from the nose. Count swallowed phlegm.) [If *no*, skip to 8C.] 1. Yes ___ 2. No ___
- B. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week? 1. Yes ___ 2. No ___
- C. Do you usually bring up phlegm at all on getting up, or first thing in the morning? 1. Yes ___ 2. No ___
- D. Do you usually bring up phlegm at all during the rest of the day or at night? 1. Yes ___ 2. No ___

IF YES TO ANY OF THE ABOVE (8A, B, C, OR D), ANSWER THE FOLLOWING:
IF NO TO ALL, CHECK *DOES NOT APPLY* AND SKIP TO NEXT SECTION.

- E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? 1. Yes ___ 2. No ___
8. Does not apply _____
- F. For how many years have you had trouble with phlegm? _____
Number of years
88. Does not apply _____

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8G. During which months does your phlegm give you the most trouble? (Check months troubled) OR: Check here if no relation to time of year _____. 8. Does not apply _____

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
___	___	___	___	___	___	___	___	___	___	___	___

EPISODES OF COUGH AND PHLEGM

9A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year? 1. Yes ___ 2. No ___
*(For persons who usually have cough and/or phlegm)

IF YES TO 9A:

B. For how long have you had at least 1 such episode per year? _____
Number of years
88. Does not apply _____

WHEEZING

10A. Does your chest ever sound wheezy or whistling:

1. When you have a cold?	1. Yes ___	2. No ___
2. Occasionally apart from colds?	1. Yes ___	2. No ___
3. Most days or nights?	1. Yes ___	2. No ___

IF YES TO 1, 2, OR 3 IN 10A:

B. For how many years has this been present?

1. When you have a cold?	_____
	Number of years
2. Occasionally apart from colds?	_____
	Number of years
3. Most days or nights?	_____
	Number of years

11A. Have you ever had an attack of wheezing that has made you feel short of breath? 1. Yes ___ 2. No ___

IF YES TO 11A:

B. How old were you when you had your first such attack? _____ Age in years
88. Does not apply _____

C. Have you had 2 or more such episodes? 1. Yes ___ 2. No ___
8. Does not apply _____

D. Have you ever required medicine or treatment for the(se) attack(s)? 1. Yes ___ 2. No ___
8. Does not apply _____

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11E. During which months does your wheezing give you the most trouble? (Check months troubled) OR: Check here if no relation to time of year_____. 8. Does not apply _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

BREATHLESSNESS

12. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to Question 14A
Nature of condition(s): _____

13A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? 1. Yes ___ 2. No ___

IF YES TO 13A:

B. Do you have to walk slower than people of your age on the level because of breathlessness? 1. Yes ___ 2. No ___
8. Does not apply _____

C. Do you ever have to stop for breath when walking at your own pace on the level? 1. Yes ___ 2. No ___
8. Does not apply _____

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level? 1. Yes ___ 2. No ___
8. Does not apply _____

E. Are you too breathless to leave the house or breathless on dressing or undressing? 1. Yes ___ 2. No ___
8. Does not apply _____

13F. For how long have you been this short of breath? _____ Number of years
88. Does not apply _____

13G. During which months do you have the most trouble with your shortness of breath? (Check months troubled) OR: Check here if no relation to time of year_____. 8. Does not apply _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time.) 1. Yes ___ 2. No ___
3. Don't get colds _____

15A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? 1. Yes ___ 2. No ___

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IF YES TO 15A:

- B. Did you produce phlegm with any of these chest illnesses? 1. Yes ___ 2. No ___
Does not apply _____
- C. In the last 3 years, how many such illnesses, with (increased) phlegm, did you have which lasted a week or more? _____ Number of illnesses
_____ No such illnesses
8. Does not apply _____

PAST ILLNESSES

16. Did you have any lung trouble before the age of 16? 1. Yes ___ 2. No ___
17. Have you ever had any of the following?
1A. Attacks of bronchitis? 1. Yes ___ 2. No ___

IF YES TO 1A:

- B. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
8. Does not apply _____
- C. At what age was your first attack? _____ Age in years
88. Does not apply _____

- 2A. Pneumonia (include bronchopneumonia)? 1. Yes ___ 2. No ___

IF YES TO 2A:

- B. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
8. Does not apply _____
- C. At what age did you first have it? _____ Age in years
88. Does not apply _____

- 3A. Hay fever? 1. Yes ___ 2. No ___

IF YES TO 3A:

- B. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
8. Does not apply _____
- C. At what age did it start? _____ Age in years
88. Does not apply _____

- 4A. Sinus trouble? 1. Yes ___ 2. No ___

IF YES TO 4A:

- B. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
8. Does not apply _____
- C. At what age did it start? _____ Age in years
88. Does not apply _____

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18A. Have you ever had chronic bronchitis?

1. Yes ___ 2. No ___

IF YES TO 18A:

B. Do you still have it?

1. Yes ___ 2. No ___
8. Does not apply _____

C. Was it confirmed by a doctor?

1. Yes ___ 2. No ___
8. Does not apply _____

D. At what age did it start?

_____ Age in years
88. Does not apply _____

19A. Have you ever had emphysema?

1. Yes ___ 2. No ___

IF YES TO 19A:

B. Do you still have it?

1. Yes ___ 2. No ___
8. Does not apply _____

C. Was it confirmed by a doctor?

1. Yes ___ 2. No ___
8. Does not apply _____

D. At what age did it start?

_____ Age in years
88. Does not apply _____

20A. Have you ever had asthma?

1. Yes ___ 2. No ___

IF YES TO 20A:

B. Do you still have it?

1. Yes ___ 2. No ___
8. Does not apply _____

C. Do you currently require medicine or treatment for asthma?

1. Yes ___ 2. No ___
8. Does not apply _____

D. Was it confirmed by a doctor?

1. Yes ___ 2. No ___
8. Does not apply _____

E. At what age did it start?

_____ Age in years
88. Does not apply _____

F. If you no longer have it, at what age did it stop?

_____ Age stopped
88. Does not apply _____

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21. Have you ever had:
- A. Any other chest illness? 1. Yes ___ 2. No ___
 If yes, please specify _____
- B. Any chest operations? 1. Yes ___ 2. No ___
 If yes, please specify _____
- C. Any chest injuries? 1. Yes ___ 2. No ___
 If yes, please specify _____
- 22A. Has a doctor ever told you that you had heart trouble? 1. Yes ___ 2. No ___

IF YES TO 22A:

- B. Have you ever had treatment for heart trouble in the past 10 years? 1. Yes ___ 2. No ___
 8. Does not apply _____

- 23A. Has a doctor ever told you that you have cancer? 1. Yes ___ 2. No ___
 If yes, please specify what type(s) and year of diagnosis _____
- | | |
|-------|----------------|
| Type | Year Diagnosed |
| _____ | _____ |
| Type | Year Diagnosed |
| _____ | _____ |
| Type | Year Diagnosed |
| _____ | _____ |
| Type | Year Diagnosed |
| _____ | _____ |

- B. Do you still have cancer? 1. Yes ___ 2. No ___
 If yes, please specify what type(s). _____ Type _____ Type

OCCUPATIONAL HISTORY

- 24A. Have you ever worked full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No ___

IF YES TO 24 A:

- B. Have you ever worked for a year or more in any dusty job? 1. Yes ___ 2. No ___
 8. Does not apply _____
- If yes, specify what kind of dust _____
- Specify job/industry _____ Total years worked _____
- Was dust exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___
- C. Have you ever been exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___
 If yes, specify what kind of chemical fumes _____
- Specify job/industry _____ Total years worked _____
- Was exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___
- D. What has been your usual occupation or job--the one you have worked at the longest?
1. Job-occupation: _____
2. Number of years employed in this occupation: _____
3. Current position-job title: _____

TOBACCO SMOKING

25A. Have you ever smoked cigarettes? (*No* means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year. 1. Yes ___ 2. No ___

IF YES TO 25A:

- B. Do you now smoke cigarettes (as of 1 month ago)? 1. Yes ___ 2. No ___
8. Does not apply _____
- C. How old were you when you first started regular cigarette smoking? _____ Age in years
88. Does not apply _____
- D. If you have stopped smoking cigarettes completely, how old were you when you stopped? _____ Age stopped
Check if still smoking _____
88. Does not apply _____
- E. How many cigarettes do you smoke per day now? _____ Cigarettes per day
88. Does not apply _____
- F. On the average of the entire time you smoked, how many cigarettes did you smoke per day? _____ Cigarettes per day
88. Does not apply _____
- G. Do you or did you inhale the cigarette smoke? 1. Does not apply _____
2. Not at all _____
3. Slightly _____
4. Moderately _____
5. Deeply _____

26A. Have you ever smoked a pipe regularly? (*Yes* means more than 12 oz. of tobacco in a lifetime.) 1. Yes ___ 2. No ___

IF YES TO 26A:

FOR PERSONS WHO HAVE EVER SMOKED A PIPE.

- B. 1. How old were you when you started to smoke a pipe regularly? _____
Age
2. If you have stopped smoking a pipe completely, how old were you when you stopped? _____ Age stopped
Check if still smoking pipe ___
88. Does not apply _____
- C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week? _____ oz. per week (a standard pouch of tobacco contains 1-1/2 oz.)
88. Does not apply _____
- D. How much pipe tobacco are you smoking now? _____ oz. per week
88. Not currently smoking a pipe _____
- E. Do you or did you inhale the pipe smoke? 1. Never smoked _____
2. Not at all _____
3. Slightly _____
4. Moderately _____
5. Deeply _____

27A. Have you ever smoked cigars regularly?
 (Yes means more than 1 cigar a week for a year.) 1. Yes__ 2. No__

IF YES TO 27A:

FOR PERSONS WHO HAVE EVER SMOKED CIGARS:

- B. 1. How old were you when you started smoking cigars regularly? _____
 Age
2. If you have stopped smoking cigars completely, how old were you when you stopped _____ Age stopped
 Check if still smoking cigars__
 88. Does not apply _____
- C. On the average, over the entire time you smoked cigars, how many cigars did you smoke per week? _____ Cigars per week
 88. Does not apply _____
- D. How many cigars are you smoking per week now? _____ Cigars per week
 88. Check if not smoking cigars currently _____
- E. Do you or did you inhale the cigar smoke?
 1. Never smoked _____
 2. Not at all _____
 3. Slightly _____
 4. Moderately _____
 5. Deeply _____

FAMILY HISTORY

28. Were either of your natural parents ever told by a doctor that they had one of the following chronic lung conditions or cancer?

	FATHER			MOTHER		
	1. YES	2. NO	3. DON'T KNOW	1. YES	2. NO	3. DON'T KNOW
A. Chronic bronchitis?	_____	_____	_____	_____	_____	_____
B. Emphysema?	_____	_____	_____	_____	_____	_____
C. Asthma?	_____	_____	_____	_____	_____	_____
D. Cancer?	_____	_____	_____	_____	_____	_____
If yes, what type(s) and year of diagnosis?	_____		_____	_____		_____
	Type	Year Diagnosed		Type	Year Diagnosed	
	_____	_____		_____	_____	
	Type	Year Diagnosed		Type	Year Diagnosed	
	_____	_____		_____	_____	
	Type	Year Diagnosed		Type	Year Diagnosed	
	_____	_____		_____	_____	
	Type	Year Diagnosed		Type	Year Diagnosed	
	_____	_____		_____	_____	
	Type	Year Diagnosed		Type	Year Diagnosed	
E. Other chest condition?	_____	_____	_____	_____	_____	_____

29A. Is parent currently alive? _____

B. Please Specify: _____ Age if living
 _____ Age at death
 8. Don't know _____

C. Please specify cause of death _____

RESIDENCE

30. When did you move into your current home? _____
(Month) (Year)
31. When did you move into this city or rural area? _____
(Month) (Year)
32. When did you move into this county? _____
(Month) (Year)
33. How long have you lived in the same part of this city or rural area? _____ Number of years
34. How many residence changes (changes of town) have you had in the last 10 years? _____ Number of changes

HOME HEATING AND FUEL

35. How is your current home heated?
- 1. Steam or hot water _____
 - 2. Warm air furnace _____
 - 3. Floor, wall, or pipeless furnace _____
 - 4. Built-in electric units _____
 - 5. Other means -- with flue _____
 - 6. Other means -- without flue _____
 - 7. Not heated _____
36. What fuel is used most for heating your current home?
- 1. Coal or coke _____
 - 2. Wood _____
 - 3. Utility gas _____
 - 4. Bottled, tank or LP gas _____
 - 5. Electricity _____
 - 6. Fuel oil, kerosene, etc. _____
 - 7. Other _____
 - 8. No fuel _____
37. What fuel is used most for cooking in your current home?
- 1. Coal or coke _____
 - 2. Wood _____
 - 3. Utility gas _____
 - 4. Bottled, tank, or LP gas _____
 - 5. Electricity _____
 - 6. Fuel oil, kerosene _____

Thank you for completing this questionnaire. Please return it in the enclosed stamped, pre-addressed envelope. If you have any questions, please call us at the following toll-free number: **877-511-2167**.

Children's Questionnaire

NAME _____
(Last) (First) (Middle Initial)

ADDRESS _____
(Street or Route No.)

(City) (County) (Zip Code)

TELEPHONE NUMBER: _____
(Area Code)

DATE QUESTIONNAIRE COMPLETED: _____

PERSON COMPLETING THE QUESTIONNAIRE:

- 1. Child's mother _____
- 2. Child's father _____
- 3. Female guardian _____
- 4. Male guardian _____
- 5. Other female _____
Specify relation _____
- 6. Other male _____
Specify relation _____

1. Sex of child?

1. Male ___ 2. Female ___

2. What is the racial-ethnic group of this child?

- 1. White _____
- 2. Black _____
- 3. Oriental _____
- 4. American Indian _____
- 5. Mexican-American _____
- 6. Other ___ Specify _____

3. Date of birth: _____
(Month) (Day) (Year)

4. In what city or town was this child's mother living when this child was born?
Please Specify: _____
(City) (County) (State)

5. Please list all cities, counties, and states where he or she lived for 6 months or longer, from birth to the present
(and the number of years at each address)

Birth year (_____): _____

Current Year _____
Number of years at current address _____

- 6A. Does he/she attend day care, nursery school or regular school?
1. No _____
 2. Day care only _____
 3. Nursery school only _____
 4. Regular school only _____
 5. Day care and nursery school _____
 6. Day care and regular school _____
 7. Nursery and regular school _____
 8. Day care, nursery and regular school _____
- B. If day care or nursery school, how many children are in his/her class or group?
- _____
Number of Children
(88. Does not apply ____)
- C. If regular school, what grade is he/she in?
- _____
Grade
(00. Kindergarten ____)
(09. Ninth grade ____)
(88. Does not apply ____)
7. What is the age of the youngest child living in this child's home?
0. If less than 6 months _____
 1. 6-17 months _____
 2. 18-29 months _____
 3. 30 months - <5 years _____
 4. 5-9 years _____
 5. 10+ years _____
 6. No children younger _____
8. How many people share his/her bedroom?
1. Own room _____
 2. 1 person _____
 3. 2 persons _____
 4. 3 or more persons _____
- 9A. How many rooms (not counting bathrooms) are there in your house/apartment?
- _____
Number of rooms
- 9B. How many people live in your home?
- Number of children _____
Number of adults _____
10. How is your home heated?
1. Steam or hot water _____
 2. Warm air furnace _____
 3. Floor, wall, or pipeless furnace _____
 4. Built-in electric units _____
 5. Other means--with flue _____
 6. Other means -- without flue _____
 7. Not heated _____
11. What fuel is used most for cooking in your home:
1. Coal or coke _____
 2. Wood _____
 3. Utility gas _____
 4. Bottled, tank or LP gas _____
 5. Electricity _____
 6. Fuel oil, kerosene _____

12. Do you have any air conditioner(s), humidifier(s), or air filter(s) in your home?

- 0. None _____
- 1. Air conditioner(s) _____
- 2. Humidifier(s) _____
- 3. Air filter(s) _____
- 4. Air conditioner(s) + humidifier(s) _____
- 5. Air conditioner(s) + air filter(s) _____
- 6. Humidifier(s) + air filter(s) _____
- 7. Air conditioner(s) + humidifier(s) + filter(s) _____

13. Do you have a cat, dog, or bird living in your home?

- 0. No _____
- 1. Cat _____
- 2. Dog _____
- 3. Bird _____
- 4. Cat + dog _____
- 5. Cat + bird _____
- 6. Dog + bird _____
- 7. Cat + dog + bird _____

These questions pertain mainly to your child's chest. please answer *yes* or *no* if possible. If a question does not appear to be applicable to your child, check the *does not apply* space.

COUGH

- 14A. Does he/she usually have a cough with colds? 1. Yes ___ 2. No ___
- B. Does he/she usually have a cough apart from colds? 1. Yes ___ 2. No ___

IF YES TO 14A OR 14B:

- C. Does he/she cough on most days (4 or more days per week) for as much as 3 months of the year? 1. Yes ___ 2. No ___
8. Does not apply _____
- D. For how many years has he/she had this cough? _____Number of years
8. Does not apply _____

CONGESTION AND/OR PHLEGM

- 15A. Does this child usually seem congested in the chest or bring up phlegm with colds? 1. Yes ___ 2. No ___
- B. Does this child usually seem congested in the chest or bring up phlegm apart from colds? 1. Yes ___ 2. No ___

IF YES TO 15A OR 15B:

- C. Does this child seem congested or bring up phlegm, sputum, or mucus from his/her chest on most days (4 or more days per week) for as much as 3 months a year? 1. Yes ___ 2. No ___
8. Does not apply _____
- D. For how many years has he/she seemed congested or raised phlegm, sputum, or mucus from his/her chest? _____Number of years
8. Does not apply _____

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16A. Does this child get attacks of (increased) cough, chest congestion, or phlegm lasting for 1 week or more each year? 1. Yes ___ 2. No ___

IF YES TO 16A:

B. For how many years? _____ Number of years
8. Does not apply _____

C. On average, how many chest colds per year does he/she get? _____ Average number per year
8. Does not apply _____

WHEEZING

17. Does this child's chest ever sound wheezy or whistling:
A. When (he/she) has a cold? 1. Yes ___ 2. No ___
B. Occasionally apart from colds? 1. Yes ___ 2. No ___
C. Most days or nights? 1. Yes ___ 2. No ___

IF YES TO 17B OR 17C:

D. For how many years has wheezing or whistling in the chest been present? _____ Number of years
8. Does not apply _____

18A. Has this child ever had an attack of wheezing that has caused him/her to be short of breath? 1. Yes ___ 2. No ___

IF YES TO 18A:

B. Has he/she had 2 or more such episodes? 1. Yes ___ 2. No ___
C. Has he/she ever required medicine or treatment for the(se) attack(s)? 1. Yes ___ 2. No ___
D. How old was this child when he/she had his/her first such attack? _____ Age in years
E. Is or was his/her breathing completely normal between attacks? 1. Yes ___ 2. No ___

19. Does this child ever get attacks of wheezing after he/she has been playing hard or exercising? 1. Yes ___ 2. No ___

20A. During the past 3 years has this child had any chest illness that has kept him/her from his/her usual activities for as much as 3 days? 1. Yes ___ 2. No ___

IF YES TO 20A:

B. Did he/she bring up more phlegm or seem more congested than usual with any of these illnesses? 1. Yes ___ 2. No ___
8. Does not apply _____

C. How many illnesses like this has he/she had in the past 3 years? 1. Less than 1 illness per year _____
2. 1 illness per year _____
3. 2-5 illnesses per year _____
4. More than 5 illnesses per year _____

D. How many of these illnesses have lasted for as long as 7 days? _____ Number of illnesses

21. Was he/she ever hospitalized for a severe chest illness or chest cold before the age of 2 years? 1. Yes, only once _____
2. Yes, 2, times _____
3. Yes, 3 or more times _____
4. No _____
22. Did this child have any other severe chest illness or chest cold before the age of 2 years? 1. Yes ____ 2. No ____

OTHER ILLNESSES

23. Has a doctor ever said that this child had any of the following illnesses, and if yes, at what age? First Diagnosed

A.	Measles (not German)	Yes ____	No ____	At age ____
B.	Sinus trouble	Yes ____	No ____	At age ____
C.	Bronchiolitis	Yes ____	No ____	At age ____
D.	Bronchitis	Yes ____	No ____	At age ____
E.	Asthmatic bronchitis	Yes ____	No ____	At age ____
F.	Pneumonia	Yes ____	No ____	At age ____
G.	Whooping cough	Yes ____	No ____	At age ____
H.	Croup	Yes ____	No ____	At age ____
I.	Cystic fibrosis	Yes ____	No ____	At age ____
J.	Cancer (if yes, specify what type(s) and date(s) of diagnosis)	Yes ____	No ____	At age ____
		_____		Date Diagnosed
		Type		
		_____		Date Diagnosed
		Type		
		_____		Date Diagnosed
		Type		
		_____		Date Diagnosed
		Type		

- If yes, does he/she still have cancer? 1. Yes ____ 2. No ____
24. Did the doctor ever say that this child had eczema before the age of 2 years? 1. Yes ____ 2. No ____
25. Does or did this child have external ear (ear canal) infections (swimmer's ear)? 1. Yes ____ 2. No ____
26. Does or did this child have frequent ear infections (middle ear):
- A. Between the age of 0 and 2? 1. Yes ____ 2. No ____
 - B. Between the ages of 2 and 5? 1. Yes ____ 2. No ____
 - C. Over age 5? 1. Yes ____ 2. No ____
27. Did this child ever require tubes to be placed in his/her ears to drain them? 1. Yes ____ 2. No ____
28. Did this child ever have an operation on his/her tonsils or adenoids? 1. Yes ____ 2. No ____
- 29A. Has a doctor ever said that this child had asthma? 1. Yes ____ 2. No ____

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IF YES TO 29A:

- B. At what age did his/her asthma begin? _____ Age in years
C. Does he/she still have asthma? 1. Yes ___ 2. No ___
D. Does he/she currently take medicine or treatment for asthma? 1. Yes ___ 2. No ___

If no to 29C:

- E. At what age did his/her asthma stop? _____ Age in years
30. Has this child ever had an operation on his/her chest? 1. Yes ___ 2. No ___
If yes, specify: _____
31. Has a doctor ever said that this child ever had heart disease? 1. Yes ___ 2. No ___
If yes, what did the doctor say it was: _____
32. When this child was born was he/she kept in the hospital after the mother went home? 1. Yes ___ 2. No ___
If yes, specify reason: _____

ALLERGY

- 33A. Has a doctor ever said that this child had an allergic reaction to food or medicine?
1. Yes, food only ___ 2. Yes, medicine only ___
3. Yes, both food and medicine ___ 4. No ___
- 33B. Has a doctor ever said that this child had an allergic reaction to pollen or dust? 1. Yes ___ 2. No ___
- 33C. Has a doctor ever said that this child had an allergic skin reaction to detergents or other chemicals (do not include poison oak or poison ivy). 1. Yes ___ 2. No ___
- 33D. Did this child ever receive allergy shots? 1. Yes ___ 2. No ___

FAMILY HISTORY

We would like to obtain some information about the parents or guardians living with this child. (In single-parent family, complete only A or B as appropriate.) Section C should be completed by all families.

A. MALE PARENT OR GUARDIAN

34. Please indicate whether the male adult is: 1. Natural father _____
2. Stepfather _____
3. Other _____
35. What is the highest grade of school he completed? _____ Total years
36. What is his present job (title)/industry? _____

37. Does he now smoke regularly (at least 1 cigarette per day or 1 oz. tobacco per month)?

- If yes:
- 1. No _____
 - 2. Cigarettes _____
 - 3. Cigars _____
 - 4. Pipe _____
 - 5. Cigarettes plus pipe
and/or cigars _____
 - 6. Pipe and cigar _____
 - 7. Don't know _____

38. Has he ever smoked regularly (at last 20 packs of cigarettes or 12 oz of tobacco in a lifetime) while living in the home with this child?

- If yes:
- 1. No _____
 - 2. Cigarettes _____
 - 3. Cigars _____
 - 4. Pipe _____
 - 5. Cigarettes plus pipe
and/or cigars _____
 - 6. Pipe and cigar _____
 - 7. Don't know _____

39. Has a doctor ever said he had:

- A. Bronchitis? 1. Yes _____ 2. No _____ 3. Don't know _____
- B. Emphysema? 1. Yes _____ 2. No _____ 3. Don't know _____
- C. Asthma? 1. Yes _____ 2. No _____ 3. Don't know _____
- D. Hay fever? 1. Yes _____ 2. No _____ 3. Don't know _____
- E. Other respiratory conditions? 1. Yes _____ 2. No _____ 3. Don't know _____

Please specify _____

F. Cancer? 1. Yes _____ 2. No _____ 3. Don't know _____

If yes, please specify type(s) and date(s) of diagnosis

_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed

Does he still have cancer? 1. Yes ___ 2. No ___

B. FEMALE PARENT OR GUARDIAN

40. Please indicate whether the female adult is:

- 1. Natural mother _____
- 2. Stepmother _____
- 3. Other _____

41. What is the highest grade of school completed? _____ Total years

42. What is her present job (title)/industry? _____

44. Has she ever smoked regularly (at least 20 packs of cigarettes or 12 oz of tobacco in a lifetime) while living in the home with this child?

- If yes:
- 1. No _____
 - 2. Cigarettes _____
 - 3. Cigars _____
 - 4. Pipe _____
 - 5. Cigarettes plus pipe and/or cigar _____
 - 6. Pipe and cigar _____
 - 7. Don't know _____

45. Has a doctor ever said she had:

- A. Bronchitis? 1. Yes _____ 2. No _____ 3. Don't know _____
- B. Emphysema? 1. Yes _____ 2. No _____ 3. Don't know _____
- C. Asthma? 1. Yes _____ 2. No _____ 3. Don't know _____
- D. Hay fever? 1. Yes _____ 2. No _____ 3. Don't know _____
- E. Other respiratory conditions? 1. Yes _____ 2. No _____ 3. Don't know _____

Please specify: _____

- F. Cancer? 1. Yes _____ 2. No _____ 3. Don't know _____

If yes, please specific type(s) and date(s) of diagnosis

_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed
_____	_____
Type	Date Diagnosed

Does she still have cancer? 1. Yes ___ 2. No ___

C. OTHER HOUSEHOLD MEMBERS

46. Are there other members of the household who currently smoke regularly (not counting persons mentioned above)? 1. Yes ___ 2. No ___
If yes, specify number ___

Thank you for completing this questionnaire. Please return it to us in the enclosed stamped, pre-addressed envelope. If you have any questions, please call us at our toll-free number: **877-511-2167**.