Questionnaire of clinical data

Smoking history:

1. Do you smoke or have you ever been smoking more than one cigarette a day during a year?

   Yes □ No □

2. If «yes « to question (1),
   How many cigarettes did you smoke during this period of time (on average)?

   ……..... cigaretts / day

   2.1 How old were you when you started to smoke regularly? …… (years)

   2.2 Have you ever tried to quit? Yes □ No □

   2.3 If you have quit smoking how old were you when you quit? …… (years)

Respiratory symptoms:

1. Do you usually have any of the symptoms listed below even if you are not having cold?

   1.1. Cough Yes □ No □

   1.2 Sputum Yes □ No □

   1.3 Piping in the chest Yes □ No □

2. Have you ever been bothered by any of these symptoms in recent years?

   2.1 Daily cough for at least three months a year during the last two years? Yes □ No □

   2.2 Dyspnea when you walk on a flat terrain or uphill? Yes □ No □

   2.2 Dyspnea when you walk at home on a flat surface? Yes □ No □

3. Have you contacted a doctor because of any of these symptoms? Yes □ No □

4. Do you still have these symptoms? Yes □ No □

5. Have you received treatment with antibiotics ("penicillin") against pneumonia or bronchitis in the last three years? Yes □ No □

If "yes" to question (5), how long ago did it happen?

0-3 months □

4-12 months □

1-2 years □

2-3 years □

More than 3 years □

Diseases:

Have you been diagnosed or treated for any of these diseases by a family doctor or at a hospital?

1. Angina pectoris (chest pain) Yes □ No □
2. Heart Infarction Yes □ No □
3. Heart surgery (bypass) Yes □ No □
4. Stenting to the heart Yes □ No □
5. Abdominal or thoracic aorta (the main blood vessel in the belly and thorax)? Yes □ No □
6. Blood vessels at the neck or legs Yes □ No □
7. High blood pressure Yes □ No □
8. Asthma Yes □ No □
9. COPD Yes □ No □
10. Chronic bronchitis Yes □ No □
11. Diabetes Yes □ No□

Medication:

1. Do you use any of these drugs?

1.1 Aspirin Yes □ No □

1.2 Statins Yes □ No □

1.3 Inhaled steroids Yes □ No □

1.4 Other medications? Yes □ No □

…….

…….

Education

How many years of education do you have (including primary school)?……. years

Do you work? Yes □ No □

If "Yes" : How long have you worked in your current profession?

If ”No”: are you:
Student □ Retired □ Housewife □ Unemployed □ Disabled □

Asbestos

1. Have you ever worked with asbestos Yes □ No □

If “yes “,

1.1 How often did you work with asbestos?
Every day □ minimum 3 days/week □ Minimum 1-2 times a month □

less than once a month □

1.2 How many years have you worked with asbestos?…….. (years)