Please answer the questionnaire. If you cannot give an exact answer, fill in using your best judgment. If there is a question you cannot answer, leave it open. For each question, place a mark in the appropriate .

Return address:
Asthma and indoor-climate survey
Department of Thoracic Medicine
5021 Haukeland Hospital

1. Symptoms from the airways

1.	Do you usually cough or clear your throat in the morning?	Yes	No
2.	Do you usually cough during the day?	Yes	No
3.	Do you usually have phlegm when coughing?	Yes	No
4.	Do you have cough for three months or more altogether during a year?	Yes	No
5.	During the last two years, have you had cough and/or phlegm in connection with a cold for more than three weeks? Yes, several times / Yes, once / Never		
6.	Are you more breathless than people of your own age when walking uphill?	Yes	No
7.	Are you breathless when you climb two flights of stairs at an ordinary pace?	Yes	No
8.	Are you breathless walking at a normal pace on level ground?	Yes	No
9.	Are you breathless while at rest?	Yes	No
10.	Do you sometimes experience attacks of breathlessness?	Yes	No
11.	Have you ever had wheezing (a wheezing sound) in your chest?	Yes	No
12.	Were you hospitalized before you were 2 years old because of lung disease (asthma, bronchitis, bronchiolitis, pneumonia)?	Yes	No
13.	Have you ever had wheezing (a wheezing sound) in your chest in the last 12 months? (By wheezing is meant high or low pitch sounds which can also be weak)	Yes	No
	If you answered no to question 13 proceed to question 15		
14.1	Have you ever been breathless at the same time you have noticed a wheezing sound in your chest?	Yes	No
14.2	Have you had such wheezing sounds in your chest even if you did not have a cold?	Yes	No
15.	Have you ever within the last 12 months awoken with a feeling of breathlessness?	Yes	No
16.	Have you ever within the last 12 months awoken with attacks of cough?	Yes	No
17.	Have you within the last 12 months had an asthmatic attack?	Yes	No

2. Allergy

18.	Have you ever had hay fever?	Yes	No	Don't know
19.	If yes, have you had hay fever within the last 12 months?	Yes	No	Don't know
19.1	When did you experience symptoms last year? *(mark one or more)*	Spring Summer		Fall Winter
20.	Have you ever had children's eczema (atopic eczema)?	Yes	No	Don't know
20.1	If yes, do you still have this eczema (atopic eczema)?	Yes	No	Don't know

3. Lung diseases

Have you ever been treated by a physician, or have you been hospitalized for one of the diseases mentioned below?

21.	**Asthma**	Yes	No	Don't know
21.1	If yes, how old were you when the disease started?	Age: |__|__| years		
21.2	If you no longer have asthma, how old were you when it stopped?	Age: |__|__| years		
22.	**Bronchitis**	Yes	No	Don't know
22.1	If yes, how old were you when the disease started?	Age: |__|__| years		
22.2	If you no longer have bronchitis, how old were you when it stopped?	Age: |__|__| years		
23.	**Emphysema**	Yes	No	Don't know
23.1	If yes, how old were you when the disease started?	Age: |__|__| years		
24.	**Chronic obstructive pulmonary disease (COPD)**	Yes	No	Don't know
24.1	If yes, how old were you when the disease started?	Age: |__|__| years		

4. Health services and social security

25.	Do you have asthma, bronchitis, emphysema, or chronic obstructive pulmonary disease?	Yes	No
	If yes, then answer questions 26-33		
26.	Are you using asthma medication now? *(including spray, metered dose inhalers, tablets)*	Yes	No
27.	Do you see a physician for the above mentioned diseases?	Yes	No
28.	If yes, du you see *(mark one or more)*	general practitioner physician employed by workplace pulmonary specialist other type of physician	

29. If yes to qt. 27, when did you last check in? |__|__| months ago
30. How many times have you been hospitalized for the above mentioned diseases the last 12 months. |__|__| times
31. Are you employed? Yes No
32. If yes, what is the total number of days you have been on sick-leave due to the above mentioned diseases within the last 12 months.
No days 0-7 days 8-30 days 31-90 days more than 90 days

33. Are you receiving disability pension due to the above mentioned diseases? Yes No

5. Smoking habits

34. Do you presently smoke daily? Yes No
35. If the answer to the last question was 'yes', do you smoke cigarettes daily? (handrolled or factory made) Yes No
36. If you do not smoke cigarettes now:
Have you smoked cigarttes daily before? Yes No
37. If the answer was 'yes', how long is it since you quit?
Less than 3 months?
3 months – 1 year?
1-5 years?
More than 5 years?
38. The following questions are to be answered *only* if you smoke currently or have smoked before
39. For how many years have you smoked daily? Number of years: |__|__|
40. How many cigarettes do you smoke or did you smoke daily?
Give number per day (handrolled or factory made) Number of cigarettes: |__|__|
41. If you smoke, has any physician advised you to quit? Yes No
42. Have you tried nicotine transdermal patches or nicotine gum? Yes No
43. Have you participated in smoking cessation courses? Yes No

6. Passive smoking

44. Are you exposed to passive smoking at home? Yes, daily Yes, sometimes No
45. If the answer was 'no', then answer:
Have you been exposed to passive smoking at home before? Yes, daily Yes, sometimes No
46. Are you exposed to passive smoking at work? Yes, daily Yes, sometimes No
47. If the answer was 'no', then answer:
Have you been exposed to passive smoking at work before? Yes, daily Yes, sometimes No
48. Did your mother smoke when she was pregnant with you? Yes No Don't know

49. Did your mother smoke when you were a child? Yes No Don't know
50. If 'yes', how old were you then?
(mark one or both alternatives) less than 5 years old 5-15 years old
51. Did others in the household smoke when you were a child? Yes No Don't know
If 'yes', how old were you then?
(mark one or both alternatives) less than 5 years old 5-15 years old

7. Indoor climate

52. Have you observed moisture damage in your house the last 2 years? Yes No
53. Have you observed moulds in your house the last 2 years? Never Sometimes Often
54. Have you or someone you have lived with ever had had pets? (Dog, cat, bird or pet rodents) Yes No
55. If yes, do you still keep pets? Yes No

8. Education and work

56. Please mark the educational level which best describes your level:
Former primary school or present 9-year primary school
Continuation school, 1-year people's college, bible school, or the like
Lower or upper secondary school, or technical school
College or university

57. Have you ever had a work-place with much dust or fumes in the air? Yes No

9. Asthma in the family

58. Have any of your following <u>biological</u> relatives had asthma?
Mother Yes No Don't know
Father Yes No Don't know
How many siblings do you/did you have? Number |__|__|
How many of your siblings have asthma? Number |__|__| Don't know
How many children have you or have you had? Number |__|__|
How many of your children have asthma? Number |__|__| Don't know

Thank you for taking the time to fill in the questionnaire.
Please return it in the enclosed reply envelope to

The Asthma and indoor climate survey
Department of Thoracic Medicine
5021 Haukeland Hospital