APPENDICES
Appendix-I

QUESTIONNAIRE FOR DATA COLLECTION

Registration no:

Name of subject: Age (yrs):

Height: Weight:

BSA (Body Surface Area)

Address Marital Status: B/M/S/W

Food Habit: Veg / Non Veg. Occupation:

Smoker/ Non Smoker:

Chief complaints (with duration):

History of present illness (In patient’s own words):

**History of past illness:** Year Duration

Disease

Frequent cold

Chronic bronchitis/Rhinitis

Tuberculosis

Asthma/ Breathlessness

Allergic lung disease

Nausea and /or vomiting

**Respiratory Questionnaire**
1. **Cough**: Y/N  
   Duration:  
   Productive/ dry/both:  
   Frequency:  
   Time: Day/ Night/ Both/ Early morning  
   Daily/ Only some days of the week  
   Did you suffer from cough for three months every year during the preceding two years?  
   Cough accompanied with fever: Y/N  
   Frequency:  
   Is your cough related to exposure to any particular substances: Yes/ No  
   If Yes, give their names:  

2. **Wheezing**:  
   Did your chest ever sound wheezy or whistling: Yes/ No  
   Duration:  
   Sputum: Yes/ No  
   Duration:  
   Colour: White/ Yellow/ Yellowish Green/ Red/ Black  
   Blood in sputum: Yes/ No  

3. **Breathlessness**: Are you usually troubled by shortness of Breath Yes/ No  
   Duration:  
   Grade I (Shortness of breath when hurrying on the level or walking up a slight incline)  
   Grade II (Shortness of breath walking at an ordinary pace on the level)  
   Grade III (Do you have to stop for breath when walking at your own pace on the level):
Grade IV  (Shortness of breath on washing and dressing)

Onset – Gradual/ Sudden,       Time

How many days in a month did you suffer from Paroxysmal breathlessness 1-3/4-7/8-14/ more.

Which appears first: Cough / breathlessness:  Day/ Night/ Both

4. **Tightness/ Discomfort of chest:**  Yes/ No  Duration:

5. **Pain in the chest:**  Yes/ No  Duration:
   Location: Localised/ shifting  Time: Day/night/ both
   How long it lasts:
   Aggravating factors:  Relieving Factors:

6. **Nasal Catarrh/ stuffiness:**  Yes/ No  Duration:
   If yes , whether due to: Common cold / irritation at work
   Place

7. **Cold:** How many colds did you have this year  0-4/5-8 /8 or more
   Duration of the episode of cold  0-7 / 8-14 more

8. **Any other chest symptom :**  Yes/ No if yes, specify
   Duration:

9. **Is there any history of Known allergy?**  If yes, what?
Appendix-II

LIST OF PUBLICATIONS
