# Cough Questionnaire

1. How long have you had the cough? _____ days _____ weeks _____ months _____ years
2. When does the cough occur? (circle one) middle of the night daytime anytime
3. Anything you know of that causes it? ________________________________________
4. What have you taken for it, and did it help? ________________________________________
________________________________________
5. Does anything make it better? ________________________________________
6. Does your cough produce any phlegm? Is yes, what color? ________________________________________

| Do you have any of the following? | Yes | No |
|---|---|---|
| 7. Sore throat | | |
| 8. Post nasal drainage | | |
| 9. Allergies | | |
| 10. Dry mouth or dry eyes | | |
| 11. Sinus problems | | |
| 12. Exposure to irritating fumes | | |
| 13. Trouble swallowing | | |
| 14. Generalized weakness | | |
| 15. Recent excessive weight loss | | |
| 16. Indigestion, heartburn, hiatal hernia, or stomach problems | | |
| 17. Emphysema, asthma or other lung problems | | |
| 18. Shortness of breath with small amounts of exercise | | |
| 19. Heart trouble | | |
| 20. Stroke | | |
| 21. Throat surgery | | |
| 22. Double vision | | |
| 23. Other recent surgery of any kind | | |
| 24. Recent hospitalization | | |
| 25. Other medical problems | | |
| 26. Have you had a recent chest x-ray? | | |
| 27. Have you had breathing tests to check for asthma? | | |
| 28. Have you seen an allergist? | | |
| 29. Have you seen a pulmonologist (lung specialist)? | | |
| 30. Have you had sinus x-rays? | | |

Name: ________________________________________ Date: ____________________