I. GENERAL INSTRUCTIONS

The Respiratory Symptoms form is completed during the interview portion of the baseline clinic visit. The interviewer must be certified and should be familiar the data editing procedures for electronic version forms with and understand the document titled “General Instructions for Completing Paper Forms” prior completing this form. ID number, Contact Year and Name are completed as described in that document.

Information in quotes is to be read to the participant. Skip rules are enclosed in boxes. When after a brief explanation doubt remains as to whether the answer should be “Yes” or “No,” the answer should be recorded as “No.”

The Respiratory Symptoms form has been adapted from the Epidemiology Standardization Protocol and the specific instructions below are taken directly from that source. Questions must be put to the participant exactly as they are printed; small changes may make unexpected large differences in responses. Unequivocal answers are recorded as such, whether they seem reasonable or not. Probing questions should rarely be needed. When they have to be asked, they should depart as little as possible form the working of the initial question, and must not be asked as to suggest any particular answer to the respondent.

II. SPECIFIC INSTRUCTIONS

A. Cough

1. Record if the participant usually has a cough. Exclude clearing throat, but include a cough with first smoke or going outside. If respondent answers “No”, skip 2 and 3.

2. This item assesses the frequency of cough during a week.

3. This item assesses the chronicity of cough over the course of a year.

B. Phlegm

4. If the respondent answers “No”, skip to Item 7. Emphasis should be placed upon phlegm as coming up from the chest and postnasal discharge is discounted. This may be determined by: “Do you raise it from your lungs, or do you merely clear it from your throat?” Some subjects admit to bringing up phlegm without admitting to cough. This claim should be accepted without changing the replies
to “cough.” Phlegm coughed up from the chest counts as positive. Include, if volunteered, phlegm with first smoke or “on first going out-of-doors.”

5. This item assesses frequency of phlegm production during a week.

6. This item assesses the chronicity of phlegm production over the course of a year.

C. Wheezing

These questions are intended to identify subjects who have occasional and/or frequent wheezing, excluding asthma. Those questions pertaining to asthma are asked in questions 13 through 17. Subjects may confuse wheezing with snoring or bubble sounds in the chest; a demonstration “wheeze” will help if further clarification is requested. Can ask, “Does your husband (or wife) regularly complain of your wheezing (not snoring) at night?” Ask question 7 and 8 of everyone; do not ask 9 if answers to 7 and 8 are “No.” Ask Item 10 of everyone; do not ask Items 11 and 12 if the response is “No.”

D. Asthma

13. If answer is “No” do not ask 14 through 17.

14. Record confirmation by a doctor.

15. Record the age of onset rounding down to the nearest whole number. If the respondent answers “years”, code it as 02. For “unknown”, draw two horizontal lines through both boxes. If a range is given such as “5 – 7 years,” use the midpoint of the range (6.5) and round down as indicated above (recording as 06).

16. Record whether participant is still asthmatic.

17. Do not ask Item 18 if Item 17 is “Yes.”

18. Record the age of cessation of asthma rounding down to the nearest whole number. If the respondent answers “years” code it as 02. For periods of less than 1 year, code as a zero. For “unknown”, draw two horizontal lines through both boxes. If a range is given such as “5 – 7 years,” use the midpoint of the range (6.5) and round down as indicated above (recording as 06).
E. Breathlessness

If a subject volunteers that he is disabled from walking by any condition other than heart or lung disease, or obviously is confined to a wheelchair or uses crutches continuously, then questions 19 – 23 are not to be asked. If asked, the questions refer to the average condition during the preceding winters. No attempt is given to separate out cardiac breathlessness. Read the items as printed and record “Yes” or “No.”

F. Administrative Information

24. Enter the month, day and year that the data was collected.

25. Record “C” if the form was completed on the computerized data entry system, or “P” if the paper form was used.

26. Enter the 3 digit JHS code for the person at the Exam Center who entered the information on this form in the boxes provided.