



	Yes	No
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

**CHEST COLDS AND CHEST ILLNESS**

18. If you get a cold, does it usually go to your chest? (usually means more than 1/2 the time)  
 Yes     No     Don't get colds
19. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?     Yes     No     Does not apply
20. Did you produce phlegm with any of these illnesses?     Yes     No     Does not apply
21. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?    Number of illnesses \_\_\_\_\_    No such illnesses \_\_\_\_\_

**RESPIRATORY SYSTEM**

	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Other Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>

Further Comment on Positive Answers: \_\_\_\_\_  
 \_\_\_\_\_

**Do you have:**

- Frequent Colds                      Yes                       No
- Chronic Cough                      Yes                       No
- Shortness of breath when walking or climbing one flight of stairs?    Yes                       No

Further Comment on Positive Answers: \_\_\_\_\_  
 \_\_\_\_\_

**Do you:**

- |                  | Yes                      | No                       |
|------------------|--------------------------|--------------------------|
| Wheeze           | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough up Phlegm  | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoke Cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
- Pack(s) per day \_\_\_\_\_ How many years \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_