

Coughing that wakes you in the morning?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Coughing that occurs mostly when you are lying down?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Coughing up blood in the last month?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Wheezing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wheezing that interferes with your job?						<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Any other lung problem that you've been told about?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Chest pain when you breathe deeply?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Any other symptoms that you think may be related to lung problems?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
5. Have you every had any of the following cardiovascular or heart problems?															
Heart Attack?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Angina?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Failure?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling in you legs or feet (not caused by walking)?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Heart arrhythmia (heart beating irregularly)?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
High blood pressure?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any other heart problem that you've been told about?						<input type="checkbox"/> Yes	<input type="checkbox"/> No				
6. Have you ever had any of the following cardiovascular or heart symptoms?															
Frequent pain or tightness in your chest?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Pain or tightness in your chest during physical activity?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Pain or tightness in your chest that interferes with you job?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
In the past two years, have you noticed your heart skipping or missing a beat?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Heartburn or indigestion that is not related to eating										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Any other symptoms that you think may be related to heart or circulation problems?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
7. Do you currently take medication for any of the following problems?															
Breathing or lung problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart trouble?						<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Blood pressure?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures (fits)?						<input type="checkbox"/> Yes	<input type="checkbox"/> No			
8. Has your wearing a respirator caused any of the following problems? If you've never used a respirator, check the following space and go to questions 9															
Eye irritation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin allergies or rashes?						<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Anxiety that occurs only when you use the respirator?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Unusual weakness or fatigue?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Any other problem that interferes with your use of a respirator?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?										<input type="checkbox"/> Yes	<input type="checkbox"/> No				