

## ASTHMA & ALLERGY RESEARCH GROUP

Thank you for showing an interest in our research unit.

This questionnaire helps us to understand *your health* and medicines. This tells us if you might be suitable for any studies at the moment, and how best we can help you if you come to see us.

Most of the questions just need a tick in the boxes marked 'YES' or 'NO'. Any details given will be treated as strictly confidential. Don't worry if you cannot answer some of the questions. We can go over the questionnaire if you come to the department.

TITLE	SURNAME
FIRST NAME(S)	
DATE OF BIRTH	
PRESENT ADDRESS	
Postcode (if known)	
HOME TELEPHONE No. (including area code)	
WORK TELEPHONE No. (if happy to be contacted on this number)	
Mobile No	
OCCUPATION	
e-mail address	

### **BREATHING AND ALLERGIES**

Do you think you are in good health? YES  NO

How far do you think you could walk before you had to stop? Is it *less than*:

Under 10 yards  Under 100 yards  Under half a mile  Over a mile

Do you have any of these health problems?

	YES	NO	Don't know	Age started
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rhinitis (itchy, streaming or blocked nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If you *do have* asthma or COPD, have you ever needed :

	YES	NO	If 'YES', when was the last time?
Prednisolone (steroid) tablets	<input type="checkbox"/>	<input type="checkbox"/>	
A&E treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Hospital admission	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever smoked? (if 'NO', ignore these smoking questions)      YES       NO       In the past

On average how many cigarettes do you or did you smoke? \_\_\_\_\_ per day

At what age did you start smoking? \_\_\_\_\_

At what age did you stop smoking? \_\_\_\_\_

Do you drink alcohol?      YES       NO

If 'YES', how much do you drink on an average week? : \_\_\_\_\_

	YES	NO
Have you ever taken aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
If 'YES', did you suffer a reaction to the aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
If 'YES', what sort of reaction _____		
Do you have pets or regular contact with animals?	<input type="checkbox"/>	<input type="checkbox"/>
If 'YES', please give details _____		
Are you allergic to any animals?	<input type="checkbox"/>	<input type="checkbox"/>
If 'YES', please give details _____		

## **OTHER HEALTH PROBLEMS**

Have you had any of the following health problems? (if 'YES', you can give details below)

	YES	NO	DON'T KNOW
Tuberculosis (TB)			
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis, wheeze, breathlessness or chest trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems (chest pain, angina, murmurs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strokes, brain haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered 'YES' for any of the health questions above, please give more details:

If you have any other medical problems that we left out, please give more details:

Are you currently having any tests or investigations for any medical conditions?

YES

NO

If 'YES', please give brief details:

**MEDICINES**

Do you take any medicines or tablets?

(Remember to include inhalers, sleeping pills, pain killers and birth control tablets if you take them)

YES

NO

If 'YES', please give details:

TABLETS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

INHALERS \_\_\_\_\_

NASAL SPRAYS \_\_\_\_\_

OTHERS \_\_\_\_\_

*If you come to see us, please remember to bring your medicines. It is the easiest way for us to check exactly what you take!*

**FAMILY HEALTH**

Does anyone in your close family suffer from any of these health problems? (mainly thinking of your parents, brothers, sisters and children)

YES

NO

Asthma

Hayfever

Rhinitis (itchy, streaming or blocked nose)

Eczema

Any other illnesses

If you answered 'YES', please give brief details:

## **OTHER CONTACT DETAILS**

Name and address of your GP:		
GP telephone number (including area code):		
Are you registered with you GP under your current address?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Can we consult you GP about your previous health and medicines?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Name and address of next of kin:		
Telephone number of next of kin:		
Relationship to next of kin (spouse, daughter etc):		

## **STUDY DETAILS**

Have you taken part in any studies elsewhere? YES  NO

If 'YES', when and where?

Do you agree to having your data and results stored on our password protected database? YES  NO

## **DECLARATION**

I agree that you can contact any study groups I have previously participated with and noted above.

I declare that to the best of my knowledge this is a true record of my medical history.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Thank you for taking the time to complete this questionnaire. Please return it in the PRE-PAID envelope provided or to either of the addresses below:-

The Asthma and Allergy Research Group  
Division of Medicine and Therapeutics  
Ninewells Hospital and Medical School  
**FREEPOST SCO 3742**  
Dundee  
DD1 9XX

The Asthma and Allergy Research Group  
**FREEPOST RLUR-YUUP-SGLK**  
Ward 12  
Perth Royal Infirmary  
Perth  
PH1 1NX