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BLISS
Birmingham Lung Improvement Studies

NHS
National Institute for Health Research

TargetCOPD QUESTIONNAIRE (GP Practice)

STUDY ID_____

Thank you for taking the time to fill in this questionnaire. Your input is very valuable so please complete as many questions as you are able and return to the receptionist.

Please try to answer every question with the closest answer possible by ticking the appropriate box.

SECTION 1: YOUR LUNG HEALTH

1. (a) Do you usually have a cough (either during the day, or night, or first thing in the morning)?

   Yes ☐

   No ☐ **(If No, go to Q2)**

   (b) Do you usually cough like this on most days for 3 consecutive months or more during the year?

   Yes ☐ → If yes, for how many years have you had this cough? .....years

   No ☐

   (c)Does the weather affect your cough? Yes ☐ No ☐

2. (a) Do you ever cough up phlegm from your chest when you don't have a cold

   Yes ☐

   No ☐ **(If No, go to Q3)**

   (b) Do you usually bring up phlegm from your chest (either during the day, or night, or first thing in the morning)? Yes ☐ No ☐

   (c) Do you bring up phlegm on most days for 3 consecutive months or more during the year?

   Yes ☐→ If yes, for how many years have you had trouble with phlegm?.....years

   No ☐

3. Have you had wheezing or whistling in the chest in the past 12 months?

   Yes ☐→ If yes, how frequently do you wheeze?

   Occasionally ☐ More often ☐

   No ☐

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4. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

   Yes ☐ No ☐

5. Do you get short of breath walking with other people of your own age on level ground or have to stop for breath after about 15 minutes when walking at your own pace?

   Yes ☐ No ☐

6. Do you have to stop for breath after walking about 100m or after a few minutes on level ground?

   Yes ☐ No ☐

7. Are you too breathless to leave the house, or breathless while dressing or undressing?

   Yes ☐ No ☐

8. Can you lie flat at night?

   Yes ☐

   No ☐ → If no, how many pillows do you need **in total**?.....

9. Do you have or have you had any allergies?

   Yes ☐

   No ☐ **(If No, go to Q11)**

10. If yes, what type of allergies? (tick any that apply)

    Hay fever ☐ Eczema ☐ Skin allergies ☐ Allergic rhinitis (nose/eye symptoms) ☐

    Food allergies ☐ Other ☐ (please specify)…….....……

11. Do you usually have a blocked or running nose? Yes ☐ No ☐

12. Over the last year has your breathing kept you from doing as much as you used to?

    Yes ☐ No ☐

SECTION 2: YOUR GENERAL HEALTH AND CIRCUMSTANCES

13. How would you describe your health in general?

    Very good ☐ Good ☐ Fair ☐ Bad ☐ Very bad ☐

14. Has a doctor ever said you have (please tick any that apply):

Asthma	☐	High blood pressure	☐
COPD	☐	Diabetes	☐
Chronic bronchitis	☐	Stroke	☐
Emphysema	☐	Lung cancer	☐
Heart disease	☐	Tuberculosis	☐

Heart failure ☐ Depression ☐

Other medical condition (please specify) ……

15. Have you ever had a paid job?

Yes ☐ Please state the occupation you have been employed in most of your life

……

.....

Please describe what you do/did in this job

……

……

……

……

No ☐

16. Have you ever worked in a job which exposed you to vapours, gas, dust or fumes?

Yes ☐

No ☐ **(If No, go to Q18)**

17. If yes, for how many years have you been exposed? .....

18. (a) Have you ever smoked as much as one cigarette a day (or one cigar a week or an ounce of tobacco a month) for as long as one year? Yes

No ☐ **(If No, go to Q19)**

(b) (b) How much do/did you smoke a day?

.....cigarettes/day .....cigars/week.....oz or .....g tobacco/week

(c) How old were you when you started smoking?.....

(d) Do you still smoke?

Yes ☐ **(If Yes, go to Q19)**

No ☐

(e) How old were you when you finally stopped smoking?.....

19. In most weeks, how many hours per week are you exposed to other people's tobacco smoke? .....

20. What is your current height without shoes? …… metres **or** ……feet.....inches

21. What is your current weight without shoes? …….kg **or**……stone…..pounds

22. Please indicate your date of birth: ……

23. Sex: Male ☐ Female ☐

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24. How would you class your ethnic group? (Please tick one)

White

English/Welsh/Scottish/Northern Irish/British ☐
Irish ☐
Gypsy/Irish Traveller ☐
Any other white background ☐

Mixed / multiple ethnic groups

White & Black Caribbean ☐
White & Black African ☐
White & Asian ☐
Other mixed ☐

Asian / Asian British

Indian ☐
Pakistani ☐
Bangladeshi ☐
Chinese ☐
Any other Asian background ☐

Black / African / Caribbean / Black British

African ☐
Caribbean ☐
Any other Black / African / Caribbean background ☐

Other ethnic group

Arab ☐
Other ☐
Prefer not to say ☐

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SECTION 3: CONTACT INFORMATION

25. Title……. First name……

Surname ……

26. Address……

……

……

……

27. Postcode……

28. Telephone number Home:……

Mobile:……

29. Email address……

30. You may be invited for further assessment; to help us schedule these appropriately please indicate your preferred appointment times (tick any when you are available)

Monday	morning	☐	afternoon	☐	evening	☐
Tuesday	morning	☐	afternoon	☐	evening	☐
Wednesday	morning	☐	afternoon	☐	evening	☐
Thursday	morning	☐	afternoon	☐	evening	☐
Friday	morning	☐	afternoon	☐	evening	☐
Saturday	morning	☐	afternoon	☐	evening	☐

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE!

PLEASE LEAVE WITH THE RECEPTIONIST