C. SYMPTOMS

Use actual wording of each question. Put X in appropriate square after each question. When in doubt record "No".

COUGH

1. Do you usually cough first thing in the morning? (on getting up)*
   (Count a cough with first smoke or on "first going out of doors". Exclude clearing throat or a single cough.)
   1 [ ] Yes 2 [ ] No

2. Do you usually cough during the day or at night? (Ignore an occasional cough.)
   1 [ ] Yes 2 [ ] No

If YES to either question 1 or 2:

3. Do you cough like this on most days for as much as three months a year?
   1 [ ] Yes 2 [ ] No 9 [ ] NA

4. Do you cough on any particular day of the week?  
   1 [ ] Yes 2 [ ] No

If YES:


PHLEGM

6. Do you usually bring up any phlegm from your chest first thing in the morning? (on getting up)* (Count phlegm with the first smoke or on "first going out of doors." Exclude phlegm from the nose. Count swallowed phlegm.)
   1 [ ] Yes 2 [ ] No

7. Do you usually bring up any phlegm from your chest during the day or at night? (Accept twice or more.)
   1 [ ] Yes 2 [ ] No

If YES to either question 6 or 7:

8. Do you bring up phlegm like this on most days for as much as three months each year?
   1 [ ] Yes 2 [ ] No

If YES to question 3 or 8:

9. How long have you had this phlegm? (cough) (Write in number of years)
   (1) [ ] 2 years or less
   (2) [ ] More than 2 years - 9 years
   (3) [ ] 10-19 years
   (4) [ ] 20+ years

*These words are for subjects who work at night