



Chronic Cough Clinic

New Patient Questionnaire

Name:

Date:

Date of Birth:

Chronic cough is often complex and can have many causes. We appreciate you answering this extended questionnaire which will help us better understand your symptoms, make an accurate diagnosis, and guide the right treatment.

1. Current Medications (including inhalers, vitamins, and herbal supplements):

2. Drug allergies:

3. When did your cough start and how long have you had it?

4. How did your cough start?

5. Please write any previous diagnosis you have been given for your cough:

6. Do you get an urge or sensation prior to your cough?

Yes

No



7. Is your cough:

Dry

Moist

Other

8. Where do you feel your cough comes from?

Chest

Throat

Both

Unsure

9. What is the pattern of your cough?

Constantly repetitive

Intermittent

Bouts/Fits

Daytime

Nighttime

Other:

10. Which of the following are likely to trigger/exacerbate your cough or throat irritation?

Talking / laughing / on the phone

Singing

Dry air

Cold air

Exercise

Strong smells / perfumes

Eating

Lying down

Smoke / inhales irritants

Shortness of breath

Stress / anxiety

Sensation in the throat

Humidity

Other / comments: _____

11. How do you normally breath?

Through mouth

Nose

Both

Unsure

12. Have you had a chest x-ray?

No

Yes

When? _____ Where? _____

Do you know the result? Please provide the report.

13. Have you seen a Respiratory / Thoracic (Lung) Specialist for your cough?

No

Yes

When? _____ Who? _____



14. What treatments have you had specific for cough? (please list all medications / inhalers etc), were they effective?

15. Do you currently smoke tobacco or any other substances?

- Yes Former

Never Substance(s): _____

Former smoker: When did you stop?

16. What is your daily intake (glasses / cups) of:

Water: _____ Alcohol: _____ Caffeine: _____

17. Do you have asthma?

- Yes How and when was it diagnosed?

- No Don't know

If yes, what are your asthma treatments?

If yes, when was your treatment last reviewed?

- | | | | |
|--|------------------------------|-----------------------------|------------------------------------|
| Is this treatment effective for your asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Partially |
| Has the asthma treatment helped your cough? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Partially |
| Do you monitor your peak flow measurements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |



18. Have you ever been diagnosed with emphysema or chronic obstructive pulmonary disease (COPD)?

Yes

No

19. Please indicate if you have had the following investigations (provide report if possible):

Spirometry / lung function tests

Yes

Bronchoprovocation (mannitol / methacholine / hypertonic saline challenge)

Yes

20. Do you snore?

Yes

If yes, do you have pauses or stops in your breathing when you sleep? _____

No

21. Have you had a sleep study to investigate for sleep disordered breathing (obstructive sleep apnoea)?

Yes

If yes, when? _____

Where? _____

Do you know the result? Please provide the report

No

22. If you have obstructive sleep apnoea. Have you received treatment?

Yes

If yes, please list (CPAP, BiPAP, surgery, dental splint): _____

No

23. Do you have gastro-oesophageal reflux symptoms?

Yes

If yes, please list: _____

No

Are you on / have you had previous treatment for gastro-oesophageal reflux disease?

Yes

If yes, please list medications: _____

No



Has the reflux medication relieved your cough?

Yes

No

Partially

24. Have you had a gastroscopy?

Yes

If yes, when? _____ Which doctor? _____

Do you know the result? Please provide the report

No

25. Do you have any nasal or sinusitis symptoms such as blocked nose, post-nasal drip, facial congestions or pain, or nasal discharge?

Yes

If yes, please list: _____

No

26. Do you have hay fever or nasal allergies (sneezing, runny eyes, itchy eyes /nose)?

Yes

No

27. Have you been treated for your hay fever / nasal / sinus symptoms? If yes, what treatment have you had?

Has the above treatment relieved your cough?

Yes

No

Partially

28. Have you had a CT scan of your sinuses?

Yes

If yes, when? _____ Where? _____

Do you know the result? Please provide the report

No



29. Do you have any problems of difficulties with your voice? Please describe:

Yes

Speaking voice

Singing voice

No

30. Do you do a lot of:

Shouting / screaming

Throat-clearing

Coughing

Vocal use

Loud talking

Vocal noises

Are you a:

Professional voice user

Singer

31. Do you experience any difficulties with swallowing?

Yes

Please describe: _____

No

Any other comments?



These following questions are designed to assess the impact of cough on various aspects of your life. Read each question carefully and answer by circling the response that best applies to you. Please answer all questions as honestly as you can.

Leicester Cough Questionnaire

Please mark the line with an X to show how severe you feel your cough is:

No cough | _____ | Worst possible cough
 [0] [50] [100]

Please circle one number for each question

1. In the last 2 weeks, have you had chest or stomach pains as a result of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

2. In the last 2 weeks, have you been bothered by sputum [phlegm] production when you cough?

1	2	3	4	5	6	7
Every time	Most times	Several Times	Sometimes	Occasionally	Rarely	Never

3. In the last 2 weeks, have you been tired because of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

4. In the last 2 weeks, have you felt in control of your cough?

1	2	3	4	5	6	7
None of the time	Hardly any time	Little of the time	Some of the time	Good bit of time	Most of the time	All of the time

5. How often during the last 2 weeks have you felt embarrassed by your coughing?

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

6. In the last 2 weeks, my cough has made me feel anxious.

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

7. In the last 2 weeks, my cough has interfered with my job, or other daily tasks.

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time



8. In the last 2 weeks, I felt that my cough interfered with the overall enjoyment of my life.

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

9. In the last 2 weeks, exposure to paints or fumes has made me cough.

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

10. In the last 2 weeks, has your cough disturbed your sleep?

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

11. In the last 2 weeks, how many times a day have you had coughing bouts?

1	2	3	4	5	6	7
All of the time [continuously]	Most times during the day	Several times during the day	Some times during the day	Occasionally through the day	Rarely	None

12. In the last 2 weeks, my cough has made me feel frustrated.

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

13. In the last 2 weeks, my cough has made me feel fed up.

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

14. In the last 2 weeks, have you suffered from a hoarse voice as a result of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

15. In the last 2 weeks, have you had a lot of energy?

1	2	3	4	5	6	7
None of the time	Hardly any time	Little of the time	Some of the time	Good bit of time	Most of the time	All of the time

16. In the last 2 weeks, have you worried that your cough may indicate serious illness?

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time

17. In the last 2 weeks, have you been concerned that other people think something is wrong with you, because of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	Good bit of time	Some of the time	Little of the time	Hardly any time	None of the time



18. In the last 2 weeks, my cough has interrupted conversation or telephone calls.

1	2	3	4	5	6	7
Every time	Most times	Good bit of time	Some of time	Little of the time	Hardly any time	None of the time

19. In the last 2 weeks, I feel that my cough has annoyed my partner, family or friends

1	2	3	4	5	6	7
Every time	Most times	Several times	Some times	Occasionally	Rarely	Never

Reflux Symptoms Index [RSI]

Within the last month, how did the following problem affect you?

0 = No problem

5 = Severe problem

1. Hoarseness or a problem with your voice	0	1	2	3	4	5
2. Clearing your throat	0	1	2	3	4	5
3. Excess throat mucus or postnasal drip	0	1	2	3	4	5
4. Difficulty swallowing food, liquids, or pills	0	1	2	3	4	5
5. Coughing after you ate, or after lying down	0	1	2	3	4	5
6. Breathing difficulties or choking episodes	0	1	2	3	4	5
7. Troublesome or annoying cough	0	1	2	3	4	5
8. Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Total:



Newcastle Laryngeal Hypersensitivity Questionnaire [LHQ]

Please circle one number for each question

1 = all of the time 2 = most of the time 3 = a good bit of the time 4 = some of the time
5 = a little of the time 6 =hardly any of the time 7 = none of the time

- 1. There is an abnormal sensation in my throat 1 2 3 4 5 6 7
- 2. I feel phlegm and mucus in my throat 1 2 3 4 5 6 7
- 3. I have pain in my throat 1 2 3 4 5 6 7
- 4. I have a sensation of something stuck in my throat 1 2 3 4 5 6 7
- 5. My throat is blocked 1 2 3 4 5 6 7
- 6. My throat feels tight 1 2 3 4 5 6 7
- 7. There is an irritation in my throat 1 2 3 4 5 6 7
- 8. I have a sensation of something pushing on my chest 1 2 3 4 5 6 7
- 9. I have a sensation of something pressing on my throat 1 2 3 4 5 6 7
- 10. There is a feeling of constriction as though needing to inhale a large amount of air 1 2 3 4 5 6 7
- 11. Food catches when I eat or drink 1 2 3 4 5 6 7
- 12. There is a tickle in my throat 1 2 3 4 5 6 7
- 13. There is an itch in my throat 1 2 3 4 5 6 7
- 14. I have a hot or burning sensation in my throat 1 2 3 4 5 6 7

Total:

Thank you for taking the time to answer this questionnaire accurately.