

NORTH COUNTY EAR, NOSE AND THROAT -
HEAD AND NECK SURGERY
Pediatric and Adult
2023 WEST VISTA WAY, SUITE J
VISTA, CA. 92083
(760)726-2440 FAX (760)726-0644

COUGH QUESTIONNAIRE

Name _____

Date _____

Please answer the following questions.

Duration 1.) How long have you had the cough? _____

Context 2.) Anything you know of that causes it? _____

Modifying 3.) Anything make it better? _____

4.) What have you taken for it and did it help? _____

Timing 5.) When does the cough occur? (middle of night, daytime, anytime) _____

Assoc 6.) Does your cough produce any phlegm? If so what color? _____

Severity 7.) How much of a problem is your cough? _____

Yes No Do you have any of the following?

PFSH 8.) Exposure to irritating fumes
 9.) Recent surgery of any kind
 10) Recent hospitalization

ROS 11) Generalized weakness
 12) Recent excessive weight loss
 13) Double vision

Yes No Do you have any of the following?

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 14) Sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> | 15) Post nasal drainage |
| <input type="checkbox"/> | <input type="checkbox"/> | 16) Dry mouth or dry eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | 17) Sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 18) Throat surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | 19) Have you had sinus x-rays? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 20) Heart trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | 21) Emphysema, asthma, or other lung problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 22) Shortness of breath with small amounts of exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | 23) Have you had a recent chest x-ray? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 24) Have you had breathing tests to check for asthma? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 25) Have you seen a pulmonologist, (lung specialist)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 26) Trouble swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | 27) Indigestion, heartburn, hiatal hernia, or stomach problem |
| <input type="checkbox"/> | <input type="checkbox"/> | 28) Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | 29) Have you seen an allergist? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 30) Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | 31) Other medical problems _____ |

For office use:

Meds with cough side effects _____

Cigarette Use _____

Notes _____

For office use only
of elements in HPI 6
PFHS area 2
ROS # reviewed 9