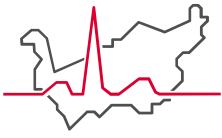


DATA COLLECTION

We thank you for the time and effort you will take to complete this questionnaire. If you are unsure of what to write, please ask the study investigator or your regular doctor.

Study ID n° :

EXPOSURE TO TOBACCO / E-CIGARETTES / CANNABIS		
1. Are you a current or former smoker of tobacco, e-cigarette or cannabis? <i>If YES, answer A-D. If NO, go to 2.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A. Do you currently smoke regularly ? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. At what age did you start smoking ? _____		
C. At what age did you quit smoking ? _____ (If you are an active smoker, check NA)	<input type="checkbox"/> NA	
D. On average, how many cigarettes do you smoke per day ? _____		
2. Have you been exposed to passive smoking ? <i>If YES, answer A-B. If NO, go to 3.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A. Have you lived in the same house as someone who smokes ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Have you been exposed to passive smoking (coffee shop, smoke-filled office?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No



YOUR FAMILY'S RESPIRATORY HEALTH

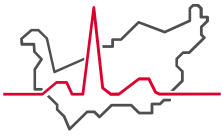
The following 3 questions concern people biologically related to you (parents, children, siblings)

3. Has someone in your family suffered from a chronic respiratory disease (asthma, COPD, cystic fibrosis, bronchiectasis, lung cancer, ...) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has anyone in your family had pulmonary fibrosis ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Has anyone in your family suffered from autoimmune diseases (rheumatoid arthritis, scleroderma, ...) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

LIVING ENVIRONMENT

The following questions ask about your home or work/leisure environment. Answer "yes" if you were exposed regularly or repeatedly, especially in the 3 years before you started having respiratory problems.

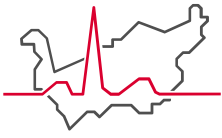
6. Jacuzzi / sauna / hot tub ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Water leaks (washing machine, dishwasher, ...) or mold in your home ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Down pillow/quilt (feather) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Birds (pigeons, chickens, canaries, ...) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Musty smell ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Has your home suffered water damage ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Do you have standing water in your house (aquarium, humidifier, aquatic plants, ...) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Do you regularly work at home with soil, compost or potted plants ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you live on a farm ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



PROFESSIONAL LIFE AND HOBBIES

The following questions ask about activities (professions and hobbies) that you have done or are currently doing. Answer YES if you have done the activity even briefly.

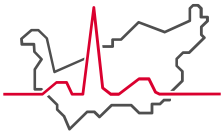
15. Work with asbestos (insulation, roofing, ...) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Insulation of buildings/floors, installation of heaters, repair of roofs ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Railway worker ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Automotive mechanics (brake linings, clutches, seals, ...) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Sandblasting/Scraping ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Plumbing/Tinsmithing ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Working with talc ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Working with beryllium ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. Working with aluminum ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. Work in the plastics industry?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. Welder ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Steel construction ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27. Foundry ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. Agriculture ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29. Road construction ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30. Tunneling ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31. Cement factory ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32. Pottery ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



DRUGS AND TREATMENTS

The following questions are specific to the drugs and treatments you have received in your lifetime. Indicate if the treatment is current, past/completed or if you have never received it.

33. Amiodarone (Cordarone®)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
34. Nitrofurantoin (Furadantine®, Uvamin®)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
35. Methotrexate (Metoject®, Methotrexat®)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
36. Radiotherapy on the thorax	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
37. Chemotherapy for cancer	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
38. Immunotherapy for cancer	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
39. Biological treatment (Rituximab, Tocilizumab...) If yes, which one? _____	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never



SYMPTOMS AND HEALTH HISTORY

Your doctor will pay close attention to your respiratory symptoms during the visit. After the first 2 questions, the questionnaire asks about your non-respiratory symptoms and your health history.

BREATHING DIFFICULTIES

9. Have you ever experienced breathing difficulties (shortness of breath, difficulty breathing) beyond what is normally expected during exercise?

Yes No

If "Yes" A. When did the difficulties arise? Month (mm): _____ Year (20xx): _____

B. Place a mark on the line below that corresponds to the current intensity of your breathing difficulties (shortness of breath, difficulty breathing)

No difficulty in breathing Unbearable difficulty to breathe

COUGH

10. Do you cough regularly? Yes No
(With or without secretions/sputum/clots/mucus/clutter)

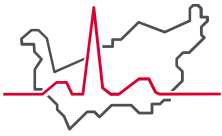
If "Yes" A. When did the cough start? Month (mm): _____ Year (20xx): _____

B. Place a mark on the line below that corresponds to the current intensity of your cough

No cough Unbearable cough

C. Is your cough accompanied by secretions?

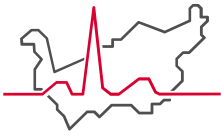
Yes No



SYMPTÔMES NON RESPIRATOIRES

11. Answer "Yes" if you regularly experience any of the symptoms listed below

- | | | |
|---|--------------------------------------|-----------------------------|
| A. Fatigue | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Stiffness (>1 hour in the morning) or joint pain or swelling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>If "Yes" What articulations:</i> | | |
| <input type="checkbox"/> Hands/wrists | <input type="checkbox"/> Shoulders | |
| <input type="checkbox"/> Knees | <input type="checkbox"/> Ankles/feet | |
| C. Difficulty swallowing or feeling of food stuck in the throat ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Permanent dryness of the eyes and mouth ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Pain or change in color (red, white, bluish) of fingers exposed to cold (Raynaud's phenomenon) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>If "Yes", starting age: _____</i> | | |
| F. Weight loss of more than 5 kg in 6 months ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Gastric burning or acidic, unpleasant mouth taste after eating ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H. Rashes on the skin (red spots) ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I. Muscle weakness (new difficulty getting up from a chair, carrying a heavy object) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



HEALTH HISTORY

12. The following questions ask about your health history. Answer "yes" if a doctor has told you at least once that you have this problem

- | | | |
|---|------------------------------|-----------------------------|
| A. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. COPD | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Lung cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Heart failure, myocardial infarction, angor, coronary artery disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Rheumatoid arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H. Scleroderma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I. Lupus erythematosus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| J. Polymyositis or dermatomyositis or anti-synthetase syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| K. Sjogren's syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| L. Gastroesophageal reflux or hiatal hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| M. Sleep apnoea syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| N. Immune deficiency or immunodeficiency (lack of antibodies) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| O. Other autoimmune disease: _____ | | |

We are very grateful for your time and effort in completing this survey.

Note: This questionnaire is largely based on one administered at the Providence Health Care Centre, St. Paul's Hospital, University of British Columbia, Vancouver, BC. The Respiratory Department at St. Paul's Hospital (Prof Chris Ryerson) agreed to its translation into French and its use in the pulmonology department at the Centre Hospitalier du Valais Romand (CHVR) and at the Hôpital Riviera Chablais (HRC).
French adaptation: P-O. Bridevaux, April 2022. All rights reserved.