**Questionnaire of clinical data**

**Smoking history:**

1. Do you smoke or have you ever been smoking more than one cigarette a day during a year?  
   - Yes □ No □

2. If «yes» to question (1), How many cigarettes did you smoke during this period of time (on average)?  
   …………………… cigarettes / day

   2.1 How old were you when you started to smoke regularly?  
      ………… (years)

   2.2 Have you ever tried to quit?  
      Yes □ No □

   2.3 If you have quit smoking how old were you when you quit?  
      ………… (years)

**Respiratory symptoms:**

1. Do you usually have any of the symptoms listed below even if you are not having cold?  
   
   1.1. Cough  
      Yes □ No □

   1.2 Sputum  
      Yes □ No □

   1.3 Piping in the chest  
      Yes □ No □

2. Have you ever been bothered by any of these symptoms in recent years?  

   2.1 Daily cough for at least three months a year during the last two years?  
      Yes □ No □

   2.2 Dyspnea when you walk on a flat terrain or uphill?  
      Yes □ No □

   2.2 Dyspnea when you walk at home on a flat surface?  
      Yes □ No □

3. Have you contacted a doctor because of any of these symptoms?  
   - Yes □ No □

4. Do you still have these symptoms?  
   - Yes □ No □

5. Have you received treatment with antibiotics ("penicillin") against pneumonia or bronchitis in the last three years?  
   - Yes □ No □
If "yes" to question (5), how long ago did it happen?

- 0-3 months
- 4-12 months
- 1-2 years
- 2-3 years
- More than 3 years

**Diseases:**

Have you been diagnosed or treated for any of these diseases by a family doctor or at a hospital?

1. Angina pectoris (chest pain)  
   - Yes □ No □
2. Heart Infarction  
   - Yes □ No □
3. Heart surgery (bypass)  
   - Yes □ No □
4. Stenting to the heart  
   - Yes □ No □
5. Abdominal or thoracic aorta (the main blood vessel in the belly and thorax)?  
   - Yes □ No □
6. Blood vessels at the neck or legs  
   - Yes □ No □
7. High blood pressure  
   - Yes □ No □
8. Asthma  
   - Yes □ No □
9. COPD  
   - Yes □ No □
10. Chronic bronchitis  
    - Yes □ No □
11. Diabetes  
    - Yes □ No □

**Medication:**

1. Do you use any of these drugs?

   1.1 Aspirin  
    - Yes □ No □
   1.2 Statins  
    - Yes □ No □
1.3 Inhaled steroids
Yes ☐ No ☐

1.4 Other medications?
Yes ☐ No ☐

Education

How many years of education do you have (including primary school)?......................... years

Do you work?
Yes ☐ No ☐

If "Yes": How long have you worked in your current profession?

If "No": are you:
Student ☐ Retired ☐ Housewife ☐ Unemployed ☐ Disabled ☐

Asbestos

1. Have you ever worked with asbestos
Yes ☐ No ☐

If “yes “,

1.1 How often did you work with asbestos?
Every day ☐ minimum 3 days/week ☐ Minimum 1-2 times a month ☐
less than once a month ☐

1.2 How many years have you worked with asbestos?............. (years)