

Smoking Status	<input type="checkbox"/> Current	<input type="checkbox"/> Former	<input type="checkbox"/> Never
Form of Tobacco	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigar	<input type="checkbox"/> Pipe
Age Started (enter a numeric value)			
Age Quit (enter a numeric value)			
Cigarettes Average smoked per day quantity (enter a numeric value)			
Cigarettes Average smoked per day units	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Packs	
Cigars Average smoked per day quantity (enter a numeric value)			
Pipe Average smoked per day Oz (enter a numeric value)			
History of chronic lung disease	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Chronic lung disease(s) present (select all that apply)	<input type="checkbox"/> Asthma <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Bronchiectasis	<input type="checkbox"/> Pulmonary fibrosis/Interstitial lung disease <input type="checkbox"/> Other	
Other chronic lung disease	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Experienced a cough, at least 4 days a week, for at least 3 months	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Experienced breathlessness that limits ability to perform: (select all that apply)	<input type="checkbox"/> Vigorous activity (hiking, jogging, heavy lifting, etc) <input type="checkbox"/> Moderate activity (brisk walking, vacuuming, mowing lawn) <input type="checkbox"/> Light activity (walking slowly, less than 1/4 mile or up 1 flight of stairs),	<input type="checkbox"/> Walking less than 20 feet or with dressing/undressing <input type="checkbox"/> Breathlessness at rest <input type="checkbox"/> None	
Used or been prescribed oxygen	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Had a transplant (bone marrow, peripheral stem cell, kidney, liver, pancreas, heart, bowel, or lung)	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Active cancer or cancer diagnosis in the past 2 years (other than skin cancer)	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Family history of pulmonary fibrosis	<input type="checkbox"/> Yes		<input type="checkbox"/> No