



Leicester Cough Questionnaire

Name: _____ Date: _____

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

← _____ →

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

← _____ →

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?

← _____ →

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

← _____ →

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
None of the Time	Hardly any of the time	A little bit of the time	Some of the time	A good bit of the time	Most of the time	All the time	

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

← _____ →

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

6. In the last 2 weeks, has your cough made you feel anxious?

← _____ →

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

8. In the last 2 weeks, have you felt that your cough interfered with the overall enjoyment of your life?

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time (continuously)	Most times during the day	Several times during the day	Sometimes during the day	Occasionally during the day	Rarely	None	

12. In the last 2 weeks, has your cough made you feel frustrated?

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

13. In the last 2 weeks, has your cough made you feel fed up?

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

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

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
None of the Time	Hardly any of the time	A little bit of the time	Some of the time	A good bit of the time	Most of the time	All the time	

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

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the 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?

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

18. In the last 2 weeks, has your cough interrupted conversation of telephone calls?

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
All the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	Hardly any of the time	None of the Time	

19. In the last 2 weeks, do you feel that your cough has annoyed your partner, family or friends?

←-----→

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	
Every time I cough	Most times when I cough	Several times when I cough	Sometimes when I cough	Occasionally when I cough	Rarely	Never	

RESULTS

Physical: _____

Psychological: _____

Social: _____

Total: _____