

TASMANIAN ASTHMA SURVEY
CHILD'S MEDICAL HISTORY – CONFIDENTIAL

This section is for office use only

Code
Survey number

Child's surname

Child's Christian name

School health number
(not to be coded)

Sex Male Female

School name

Child's school number

To be filled in by parent, guardian or relative

IMPORTANT

(a) Before completing this form, please indicate your relationship to the child named in the panel above by putting a cross (☒) in the appropriate square below:

- Mother Other relation
 Father No relation
 Step-parent or adopted parent or guardian

(b) Has the child named above got a twin, or any brothers or sisters born in the same year (that is 1961)? (*put a cross in the appropriate square*)

- Yes,
please give Christian names and the name of the school the brother or sister attends:

Name

School

- No

(c) Please state the number of living full brothers and sisters in the family (excluding any born in 1961).

(d) If you do not read English well and have difficulty understanding the questions for this reason, please put a cross here

(e) Please name the local doctor or hospital usually attended by this child for any ailment.

HOW TO ANSWER THE QUESTIONS:

In most cases, unless otherwise indicated, you are asked to answer YES or NO by putting a cross☒ in the appropriate square. Sometimes, if the answer is not simply YES or NO, there are more than two squares provided, but you should still put a cross in only one of the several squares. Only three questions (relating to months of the year) may need a cross in more than one square, but these exceptions are specifically mentioned.

Please make sure that **ALL** questions are answered; please do not omit one, as this might mean we cannot use the other information you will have given us. We understand that the answers to some questions can only be approximate, just as we understand that one's memory cannot always be perfectly accurate. If you wish to add more information or more details, please do so on a separate sheet of paper. Do **NOT** write extra notes on the form, and always answer the question with a cross in the most appropriate square, even if you add extra notes on a separate piece of paper.

Note that there are really four separate forms—the first deals with the health of the child named in the panel above, the second deals with the health of the mother, the third with the health of the father, and the fourth with the health of brothers and sisters. All these are equally important in helping us to understand the importance of the whole family in respiratory and allergic illnesses.

1. (a) Where was he/she born?

Tasmania

Other Australian State

United Kingdom, New Zealand, South Africa, Canada,
United States of America

Other overseas country

Please name

(b) Date of birth

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>day</i>			<i>month</i>			<i>year</i>			

2. Did he/she have infantile (baby) eczema? Yes No

3. Has he/she ever had eczema in the creases (bends) of
elbows, wrists, or knees? Yes No

4. How was he/she fed in the first three months of life?

Breast only

Bottle only

Breast and bottle

5. Does he/she have a stutter or stammer? Yes No

6. Has he/she have a habit of biting the fingernails? Yes No

7. During the first three years of life, did you have to take the
child to the doctor because of difficulties with feeding?

Often

Occasionally

Never

8. For how much time in the last twelve months has the child
been confined to the house because of chest illnesses?

Not at all

One to seven days

Eight to thirty days

More than a month

9. Has he/she had the tonsils removed? Yes No

10. Has he/she had **more** than two sore throats or attacks of tonsillitis in the past twelve months? Yes No
11. Have you ever been told by a doctor that he/she had pneumonia or pleurisy?
- No, Never
- Yes, Once or twice
- Yes, More than twice
12. Have you been told by a doctor that he/she is allergic to any foods or medicines? Yes No
13. Does he/she get hives?
- Never
- Once or twice a year
- More than twice a year
14. Has he/she **at any time** in his/her life suffered from attacks of asthma or of wheezy breathing? Yes No
- (**Note:** Please regard “asthma” and “wheezy breathing” as being much the same thing for this survey; we do not ask you to try to tell the difference).

The following questions (Nos. 15 to 21) relate to the details of these illnesses, and need to be answered if the answer to question 14 was YES. If the answer to question 14 was NO, omit these questions and go on to question 21.

15. How long is it since the last attack?
- Less than a month ago
- Over one but less than three months ago
- Over three but less than six months ago
- Over six but less than twelve months ago
- Over one year but less than two years ago
- Over two years ago
16. On the average (as near as you can say), how often do these attacks tend to occur over the last two years or so?
- About once in twenty-four hours
- About once a week
- About once a fortnight

- About once a month
- About once every three months
- About once every six months
- About once a year (or less often)
- No attacks at all in the last two years

17. On the average (as near as you can say), how long do these attacks usually last (with usual treatment)?

- Less than twelve hours
- A days or so
- A week or so
- A month or so
- “Continuous” (never free of asthma or wheezing for more than a day or two)

18. At what age did these attacks begin?

- Under 1 year
- Over 1 and under 2 years
- Over 2 and under 3 years
- Over 3 and under 4 years
- Over 4 and under 5 years
- Over 5 and under 6 years
- Over 6 and under 7 years
- Over 7 years

19. Since the attacks began, approximately how many has he/she had altogether?

- One attack only
- Two to five attacks
- Six to ten attacks
- Eleven to twenty attacks
- Over twenty attacks

20. If the attacks tend to be more frequent or more severe at any particular time of the year, indicate the "bad" months by putting a cross in the appropriate square(s) (but DO NOT put a cross against more than FOUR of the twelve months). If no month is worse than the others, leave all squares blank.

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→ 21. Has he/she **at any time** in his/her life suffered from attacks of bronchitis or attacks of cough with sputum (phlegm) in the chest ("loose" or "rattly" cough)?

Yes No

(Note: Please regard "bronchitis", "cough with sputum (phlegm) in the chest" and "loose or rattly cough" as being much the same thing for this survey; we do not ask you to try to tell the difference).

The following questions (Nos. 22 to 27) relate to the details of these illnesses, and need to be answered if the answer to question 21 was YES. If the answer to question 21 was NO, omit these questions and go on to question 28.

22. How long is it since the last attack?

- Less than a month ago
- Over one but less than three months ago
- Over three but less than six months ago
- Over six but less than twelve months ago
- Over one year but less than two years ago
- Over two years ago

23. On the average (as near as you can say) how often do these attacks tend to occur over the last two years or so?

- About once in twenty-four hours
- About once a week
- About once a fortnight
- About once a month
- About once every three months
- About once every six months
- About once a year (or less often)
- No attacks at all in the last two years

- 28. Does he/she get attacks of “hay fever” (that is, sneezing, running or blocked nose, sometimes with itchy eyes or nose)? Yes No

If the answer to question 28 is NO, omit question 29.

29. If these hay fever attacks tend to be more frequent or more severe at any particular time of the year, indicate the “bad” months by putting a cross in the appropriate square(s) (but DO NOT put a cross against more than FOUR of the twelve months). If no month is worse than the others, leave all squares blank.

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30. Is he/she prone to “colds in the heat” (that is, more than two or three colds a year)? Yes No

If the answer to question 30 is NO, omit question 31.

31. If these head colds tend to be more frequent or more severe at any particular time of the year, indicate the “bad” months by putting a cross in the appropriate square(s) (but DO NOT put a cross against more than FOUR of the twelve months). If no month is worse than the others, leave all squares blank.

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32. Has he/she ever had a chest X-ray? Yes No

If the answer is YES:

Where was the X-ray taken? (Name of hospital, doctor or clinic)

What year was it taken? 19

Was it normal, as far as you know? Yes No

33. Has he/she ever attended a chest clinic as a contact of a person with tuberculosis? Yes No

Please check your answers to all the questions. Thank you.

TASMANIAN ASTHMA SURVEY
HEALTH OF MOTHER – CONFIDENTIAL

This section is for office use only

Code
Survey number

Child's surname

Child's Christian name

School health number
(not to be coded)

Sex Male Female

School name

Child's school number

IMPORTANT

(a) Before completing this form, please indicate your relationship to the child named in the panel above by putting a cross () in the appropriate square below:

- Mother Other relation
 Father No relation
 Step-parent or adopted parent or guardian

(b) This form seeks information about the actual mother of the child named above so that we can study the possible importance of heredity. Naturally, we would prefer that she filled it in, but if the mother is not available, information would still be welcomed on any of the questions below, **provided** you can be reasonably definite from your own knowledge of the mother's health. If you feel you cannot give any useful or reliable information, please put a cross here and pass on to the next form.

Mother's surname and Christian name

Age

1. Do you go out to work (part or full-time)? Yes No
2. Have you **ever** had asthma or attacks of wheezing like asthma? Yes No
3. Do you suffer from chronic bronchitis, or from more than one attack of bronchitis every three years or so? Yes No
4. Have you **ever** suffered from "hay fever"? Yes No
5. Do you suffer frequently from "colds in the head" (that is, more than three colds a year)? Yes No
6. Have you ever been told by a doctor that you have a chest complaint called "emphysema"? (If you have never heard of emphysema, record your answer as NO). Yes No
7. Do you usually have a cough either first thing in the morning or some time during the day? ("Usually" means on three or four days in the week, or for three or four months of the year) Yes No
8. Do you usually clear or bring up some phlegm (sputum) from your chest in the mornings or during the day? ("Usually" means on three or four days of the week, or for three or four months of the year) Yes No
9. Do you smoke every day (or six days out of seven)? Yes No

If your answer to question 9 is NO, omit question 10 and go on to question 11.

10. How much do you smoke?
 - More than 20 cigarettes a day
 - Six to 20 cigarettes a day
 - Less than 6 cigarettes a day
11. Are you troubled by shortness of breath when hurrying on the level or walking up a slight rise so that you cannot keep up with other people of your own age? (NOTE: If you are physically handicapped, so that you cannot take walking exercise, put a cross in the square for "not applicable")
 - Yes
 - No
 - Not applicable

12. Are you able to keep up when walking on the flat with other people of your own age? (NOTE: If you are physically handicapped so that you cannot take walking exercise, put a cross in the square for "not applicable").

- Yes
- No
- Not applicable

13. Has any brother or sister of this child died of a chest illness? Yes No

If the answer is NO, omit the remaining questions.

If the answer is YES, please state:

	1		2	
Year of deceased child's birth	<input type="text"/>		<input type="text"/>	
Year of death	<input type="text"/>		<input type="text"/>	
Sex	<input type="text"/>		<input type="text"/>	
Illness causing death	<input type="text"/>		<input type="text"/>	
	Yes	No	Yes	No
Did the child ever suffer from asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the child suffer from bronchitis on more than one occasion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check your answers to all the questions. Thank you.

TASMANIAN ASTHMA SURVEY
HEALTH OF FATHER – CONFIDENTIAL

This section is for office use only

Code
Survey number

Child's surname

Child's Christian name

School health number
(not to be coded)

Sex Male Female

School name

Child's school number

IMPORTANT

(a) Before completing this form, please indicate your relationship to the child named in the panel above by putting a cross () in the appropriate square below:

- Mother Other relation
 Father No relation
 Step-parent or adopted parent or guardian

(b) This form seeks information about the actual father of the child named above so that we can study the possible importance of heredity. Naturally, we would prefer that he filled it in, but if the father is not available, information would still be welcomed on any of the questions below, **provided** you can be reasonably definite from your own knowledge of the father's health. If you feel you cannot give any useful or reliable information, please put a cross here and pass on to the next form.

Father's surname and Christian name

Age

1. Please indicate your occupation
2. Have you **ever** had asthma or attacks of wheezing like asthma? Yes No
3. Do you suffer from chronic bronchitis, or from more than one attack of bronchitis every three years or so? Yes No
4. Have you **ever** suffered from "hay fever"? Yes No
5. Do you suffer frequently from "colds in the head" (that is, more than three colds a year)? Yes No
6. Have you ever been told by a doctor that you have a chest complaint called "emphysema"? (If you have never heard of emphysema, record your answer as NO). Yes No
7. Do you usually have a cough either first thing in the morning or some time during the day? ("Usually" means on three or four days in the week, or for three or four months of the year) Yes No
8. Do you usually clear or bring up some phlegm (sputum) from your chest in the mornings or during the day? ("Usually" means on three or four days of the week, or for three or four months of the year) Yes No
9. Do you smoke every day (or six days out of seven)? Yes No
- If your answer to question 9 is NO, omit question 10 and 11, and go on to question 12.**
10. Do you smoke
- (a) cigarettes? Yes No
- (b) a pipe? Yes No
- (c) a cigars? Yes No

Note: If you smoke a pipe and cigarettes on most days, answer YES to (a) and (b), and NO to (c). If you mostly smoke cigarettes and only **rarely or occasionally** smoke a pipe or cigars, answer YES to (a) and NO to (b) and (c). If you mostly smoke a pipe and only **rarely or occasionally** smoke cigarettes, answer NO to (a) and (c), and YES to (b)

11. If you smoke cigarettes, how much do you smoke each day?
- More than 20 cigarettes a day
 - Six to 20 cigarettes a day
 - Less than 6 cigarettes a day
12. Are you troubled by shortness of breath when hurrying on the level or walking up a slight rise so that you cannot keep up with other people of your own age? (NOTE: If you are physically handicapped, so that you cannot take walking exercise, put a cross in the square for “not applicable”)
- Yes
 - No
 - Not applicable
13. Are you able to keep up when walking **on the flat** with other people of your own age? (NOTE: If you are physically handicapped so that you cannot take walking exercise, put a cross in the square for “not applicable”).
- Yes
 - No
 - Not applicable

Please check your answers to all the questions. Thank you.

TASMANIAN ASTHMA SURVEY
HEALTH OF BROTHERS AND SISTERS – CONFIDENTIAL

This section is for office use only

Code
Survey number

Child's surname

Child's Christian name

School health number (not to be coded)

Sex Male Female

School name

Child's school number

IMPORTANT

(a) Before completing this form, please indicate your relationship to the child named in the panel above by putting a cross (X) in the appropriate square below:

- Mother Other relation
 Father No relation
 Step-parent or adopted parent or guardian

(b) This form seeks information about the actual brothers and sisters of the child named in the panel above. Use a separate set of questions for each brother or sister.

If the child has any half-brothers or half-sisters (step-brothers or step-sisters), please put a cross here

However, only **full brothers and sisters** of the child need to be included in the detailed form below. If you do not know enough about the child's full brothers and sisters to fill in the form completely, please give at least their names, sex and approximate year of birth in the spaces provided.

Surname and Christian name

Sex

Male Female

Date of birth

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>day</i>			<i>month</i>			<i>year</i>			

1. Has he/she **ever** had asthma or attacks of wheezing like asthma? Yes No
2. Has he/she **ever** been diagnosed by a doctor as suffering from chronic bronchitis or from recurrent bronchitis (more than three or four **attacks** of bronchitis) Yes No
3. Has he/she been diagnosed by a doctor as having a chest condition called "bronchiectasis"? (If you have not heard of bronchiectasis, record the answer as NO). Yes No
4. Has he/she been confined to the house, or to bed, for a total of more than seven days in the last year because of asthma, bronchitis, coughs and colds? Yes No
5. Does he/she suffer from "hay-fever"? Yes No
6. Does he/she suffer frequently from "colds in the head" (that is, more than three colds a year)? Yes No
7. Did he/she have infantile (baby) eczema? Yes No
8. Has he/she **ever** had eczema in the creases (bends) of elbows, knees or wrists? Yes No
9. Has he/she had tonsils removed? Yes No

Please check your answers to all the questions. Thank you.

Surname and Christian name

Sex

Male Female

Date of birth

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>day</i>			<i>month</i>			<i>year</i>			

1. Has he/she **ever** had asthma or attacks of wheezing like asthma? Yes No
2. Has he/she **ever** been diagnosed by a doctor as suffering from chronic bronchitis or from recurrent bronchitis (more than three or four **attacks** of bronchitis) Yes No
3. Has he/she been diagnosed by a doctor as having a chest condition called "bronchiectasis"? (If you have not heard of bronchiectasis, record the answer as NO). Yes No
4. Has he/she been confined to the house, or to bed, for a total of more than seven days in the last year because of asthma, bronchitis, coughs and colds? Yes No
5. Does he/she suffer from "hay-fever"? Yes No
6. Does he/she suffer frequently from "colds in the head" (that is, more than three colds a year)? Yes No
7. Did he/she have infantile (baby) eczema? Yes No
8. Has he/she **ever** had eczema in the creases (bends) of elbows, knees or wrists? Yes No
9. Has he/she had tonsils removed? Yes No

Please check your answers to all the questions. Thank you.

Surname and Christian name

Sex

Male Female

Date of birth

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>day</i>			<i>month</i>			<i>year</i>			

1. Has he/she **ever** had asthma or attacks of wheezing like asthma? Yes No
2. Has he/she **ever** been diagnosed by a doctor as suffering from chronic bronchitis or from recurrent bronchitis (more than three or four **attacks** of bronchitis) Yes No
3. Has he/she been diagnosed by a doctor as having a chest condition called "bronchiectasis"? (If you have not heard of bronchiectasis, record the answer as NO). Yes No
4. Has he/she been confined to the house, or to bed, for a total of more than seven days in the last year because of asthma, bronchitis, coughs and colds? Yes No
5. Does he/she suffer from "hay-fever"? Yes No
6. Does he/she suffer frequently from "colds in the head" (that is, more than three colds a year)? Yes No
7. Did he/she have infantile (baby) eczema? Yes No
8. Has he/she **ever** had eczema in the creases (bends) of elbows, knees or wrists? Yes No
9. Has he/she had tonsils removed? Yes No

Please check your answers to all the questions. Thank you.

TASMANIAN ASTHMA SURVEY
SCHOOL TEACHER'S ASSESSMENT – CONFIDENTIAL

This section is for office use only

Code
Survey number

Child's surname

Child's Christian name

School health number (not to be coded)

Sex Male Female

School name

Child's school number

Please answer each question by putting a cross in the appropriate square. From your own observations and from any other reliable information available to you:

1. Is this child more liable to "head colds", "hay fever" or a "snuffly nose" than most members of the class? Yes No
2. Is this child more liable to bronchitis or a loose ("chesty") cough than most members of the class? Yes No
3. Does the child suffer from asthma or wheezing?
Yes — More or less constantly
Yes — Frequently (more than once a month)
Yes — Occasionally (once a month or less often)
No
4. Is the child's physical activity restricted by shortness of breath, asthma or wheezing?
Never
At times only
More or less constantly
5. If your knowledge of the child is insufficient to allow an answer to these questions, please put a cross here

TASMANIAN ASTHMA SURVEY
CLINICAL DATA – CONFIDENTIAL

This section is for office use only

Code

Survey number

Child's surname

Child's Christian name

School health number
(not to be coded)

Sex Male Female

School name

Child's school number

Date of examination / /
day month year

Medical Officer's number

Height (ins.)

Weight (lbs.)

Scales calibration 28 lbs. =

56 lbs. =

Flexural eczema (knees, elbows and wrists)

Yes No

Generalised eczema

Yes No

Nasal discharge

None

Present mucoid

Present coloured

Post nasal discharge

Yes No

Chest deformity

1. Kyphosis

2. Scoliosis

3. Funnel

4. Pigeon

5. "Asthmatic"

	Severe	Mild	Absent
1. Kyphosis			
2. Scoliosis			
3. Funnel			
4. Pigeon			
5. "Asthmatic"			

Cough

Dry

Loose

Would not cough

Audible wheezing

Yes No

Auscultation

Normal

Rhonchi unilateral

 bilateral

Rales unilateral

 bilateral

RESULTS (Office use only)

F.E.V. 0.5 (mL)

F.E.V. 1.0 (mL)

V.C. (mL)

Ratio F.E.V./V.C.

M.E.F.R. (mL/sec)

TASMANIAN ASTHMA SURVEY
MEDICAL DIAGNOSIS – CONFIDENTIAL

This section is for office use only

Code
 Survey number

Child's surname

Child's Christian name

School health number (not to be coded)

Sex Male Female

School name

Child's school number

Section A. Child's Medical Diagnosis

Tuberculin test	Pos <input type="checkbox"/>	Neg <input type="checkbox"/>	Not known <input type="checkbox"/>
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Parental evidence for

	Definite	Doubtful	Absent
Infantile eczema			
Flexural eczema			
U. R. T. abnormality			
"Asthma"			
"Bronchitis"			

Tonsils removed Yes No

School Teacher evidence for

U. R. T. abnormality Yes No

L. R. T. abnormality Yes No

Medical evidence for

Eczema

Yes No

U. R. T. abnormality
L. R. T. abnormality
“Asthma”
“Bronchitis”

	Definite	Doubtful	Absent
U. R. T. abnormality			
L. R. T. abnormality			
“Asthma”			
“Bronchitis”			

Overall assessment of child

Infantile eczema
Flexural eczema
U. R. T. abnormality
L. R. T. abnormality
“Asthma”
“Bronchitis”

	Definite	Doubtful	Absent
Infantile eczema			
Flexural eczema			
U. R. T. abnormality			
L. R. T. abnormality			
“Asthma”			
“Bronchitis”			

Section B. **Parents Medical Diagnoses**

	Definite	Doubtful	Absent
Mother —Evidence of U. R. T. abnormality			
Evidence of L. R. T. abnormality			
Father —Evidence of U. R. T. abnormality			
Evidence of L. R. T. abnormality			

Section C. **Siblings Medical Diagnoses**

	Definite	Doubtful	Absent
No. with evidence of (a) Eczema			
(b) U. R. T. abnormality			
(c) L. R. T. abnormality			

Results of Spirometry (not to be coded on this form)

F.E.V. 0.5 (mL)

F.E.V. 1.0 (mL)

V.C. (mL)

Ratio F.E.V./V.C.

M.E.F.R. (mL/sec)

TASMANIAN ASTHMA SURVEY
FAMILY RECORD – FOR OFFICE USE ONLY

This section is for office use only

Code
 Survey number

Child's surname

Child's Christian name

School health number (not to be coded)

Sex Male Female

School name

Child's school number

Mother available Yes No
 Information recorded Yes No
 Father available Yes No
 Information recorded Yes No

Siblings Born in 1961

Name	School No.	TAS./10 Completed
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>

Siblings excluding those born in 1961

Number

Number recorded

Assistance required to fill in forms

Considerable

A little

None

Unco-operative in spite of personal interview

Language barrier insuperable

Child unable to participate owing to:

1. Absence from school

2. Geographical isolation

3. Physical handicap

4. Mental deficiency