

# DIARY

	Monday 1 Feb.	Tuesday 2 Feb.	Wednesday 3 Feb.	Thursday 4 Feb.	Friday 5 Feb.	Saturday 6 Feb.	Sunday 7 Feb.
<b>DID YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS TODAY?</b>							
Write down in every square if you have had these symptoms and in which degree: 0 = no, 1 = slight, 2 = severe							
Chest pain							
Chest pain at physical exertion							
Shortness of breath							
Feeling tired or weak							
Tripping or racing heart							
Cold hands or feet							
Cough							
Phlegm							
Woken up with breathing problems							
Wheeze							
Common cold or flue							
Fever							
Avoidance of physically demanding activities because of symptoms							
How would you rate your overall health today? (1=good, 2=quite good, 3=average 4=bad, 5=very bad)							
<b>MEDICATION FOR RESPIRATORY OR CARDIAC CONDITIONS (ONLY medication you take as needed or alter doses daily) Write down the number of inhalations or capsules of the medicines you have taken:</b>							
Brand and Dose:							
Brand and Dose:							
Brand and Dose:							
Brand and Dose:							
How long have you been outside? (write down to the nearest hour)							
Have you been out of town for more that 8 hrs? (yes or no, if yes indicate where else)							

REMARKS:

**CLINICAL VISIT LOG BOOK:**

Patient Identification number: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse filling out the questionnaire: \_\_\_\_\_ (number)

**Interview:**  Yes                      **Diary changed:**  Yes                      **Urine sample:**  Yes  
No, why? \_\_\_\_\_

1.     **ECG 1 min strip:**                       Nurse id: \_\_\_\_\_

No. of Holter recorder: \_\_\_\_\_                      No. of patient cable: \_\_\_\_\_

Were there difficulties to locate the electrodes like previously?                       Yes      No  
If yes, please specify why:

**Set the time of the recorder to 23.56. Stop the recorder. Restart it. When the clock turns to 00.00 start the stopwatch.**

Real time of start of Holter recording. \_\_\_\_\_ h \_\_\_\_\_ min  
Wait 45 sec gain setting period.  
Wait 1 min for the calibration signal.

2.     **Rest** in supine position 5 min: Time since start: \_\_\_\_\_ m \_\_\_\_\_ sec                      Press the event marker.  
**Breathing frequency** for 1 min, between about 3 - 4 min: \_\_\_\_\_ /min  
Press the event marker in the end.

3.     **Paced breathing** for 5 min:                      Time since start: \_\_\_\_\_ m \_\_\_\_\_ sec                      Press the event marker.  
(Press the marker after first the paced period)                      Press the event marker in the end.

4.     **Blood pressure** measurements in supine position:  
1. \_\_\_\_\_ / \_\_\_\_\_     wait 45 sec     2. \_\_\_\_\_ / \_\_\_\_\_

5.     **Standing** for 5 min:                      Time since start: \_\_\_\_\_ m \_\_\_\_\_ sec                      Press the event marker  
**Blood pressure** at 3 min: \_\_\_\_\_ / \_\_\_\_\_  
Press the event marker in the end.

6.     **6 min exercise:**                      Time since start: \_\_\_\_\_ m \_\_\_\_\_ sec                      Press the event marker  
HR in the end: \_\_\_\_\_ /min     Load in the end: \_\_\_\_\_ W  
Press the event marker in the end.

Exercise test complete?                       Yes      No

If no, the exercise test had to be stopped, because  
development of symptoms (specify):                        
equipment problems:                        
other (specify):                     

Questions for the patient:  
Did you experience shortness of breath during the exercise test?                       Yes      No  
Did you experience chest pain during the exercise?                       Yes      No

7.     **10 min rest** in supine position: Time since start: \_\_\_\_\_ m \_\_\_\_\_ sec                      Press the event marker  
**Breathing frequency** for 1 min, between about 7 - 8 min: \_\_\_\_\_ /min  
Press the event marker in the end.

8.     End of Holter:     **ECG 1 min strip:**

9.     **Spirometry:**                      Number of spirometer: \_\_\_\_\_ Nurse id: \_\_\_\_\_                       Yes      No  
Maneuver complete:

If no, the maneuver had to be stopped, because:  
the patient was unable to perform                           development of severe symptoms                        
equipment problems                           other (specify)                     

Add remarks on the other side

Date: \_\_\_\_\_ Subject ID: \_\_\_\_\_

### QUESTIONNAIRE

1. Did you have chest pain yesterday? Yes / No

2. Did you have chest pain or other symptoms of angina pectoris during the preceding hour? Yes / No  
If yes, no exercise

3. Did you have shortness of breath yesterday? Yes / No

4. Did you have shortness of breath during the preceding hour? Yes / No  
If yes, no exercise

5. Did you have wheeze during the preceding hour? Yes / No  
If yes, no exercise

6. Did you have an airway infection in the past two weeks? Yes / No

*An airway infection is considered to be present if cold, flue, influenza, throat pain, cough, sinus infections or exacerbation of chronic bronchitis are present.*

If yes:

6.1 Do you have it today?

7. Did you have fever in the last week?  If yes, no exercise

*Comment for the nurse: Do you think the subject can perform the exercise? Yes / No*  
*If no: Why?  resp. Infection  does not want  other (specify)*

9. Did you visit a doctor for any acute illness during the past 2 weeks? Yes / No

If yes:

For what reason?

Angina Pectoris?

Other cardiac? Specify.

Respiratory condition? Specify.

Urinary tract infection?

Other.

10. Did you stay in the hospital because of this illness? Yes / No

11. Has there been any changes made in your prescriptions? Yes / No

If yes, please specify dose and brand name as prescribed. (*update the medication sheet*)

---

---

---

12. Did you take your medication today as prescribed? Yes / No  
If not, please specify:

---

---

---

13. Did you use any inhalator in the last 4 hours? Yes / No

If yes:             beta-agonist     cortical steroids             anti-cholinergic

*If question 13 is answered with 'YES' , wait with performing the pulmonary function test until one hour has passed.*

14. Did you smoke during the past 2 weeks? Yes / No

If yes:

14.1 How many cigarettes in total did you smoke during the past 2 weeks?

1-5    /    6-10    /    20-40    /    40+

14.2 Did you smoke in the last hour? Yes / No

*If question 14.2 is answered with 'YES' , wait with performing the pulmonary function test until one hour has passed.*

15. Have you been in rooms where people smoked during the last 24 hours? Yes / No

15.1 If yes, how long did you stay there? Hours

16. How did you arrive to the clinical visit?

Walking/ cycling            car/ bus/ tram            metro

17. How many cups of coffee or tea did you drink during the last 4 hours?            \_\_\_\_\_ Coffee cups

\_\_\_\_\_ Tea cups

17.1 Did you drink coffee during the last hour? Yes / No

17.2 Did you drink tea during the last hour? Yes / No

18. Did you drink alcohol during the last 24 hours? Yes / No