

Q Generic Confounders

Record ID

Questionnaire - Metadata

Session ID

Questionnaire Started At

Questionnaire Completed At

Questionnaire Duration (seconds)

Smoking

Have you smoked at least 100 cigarettes in your entire life? (There are 20 cigarettes in a pack.)?

- ☐ Yes
☐ No
☐ Don't know
☐ Prefer not to answer

Do you now smoke cigarettes every day, some days, or not at all?

- ☐ Every day
☐ Some days
☐ Not at all
☐ Don't know
☐ Prefer not to answer

How old were you when you first started regular cigarette smoking?

- ☐ Specify
☐ Don't know
☐ Prefer not to answer

Age:

If you have completely stopped smoking cigarettes, about how old were you when you stopped?

- ☐ Specify
☐ Don't know
☐ Prefer not to answer

Age when you stopped smoking:

How many years have you or did you smoke cigarettes?

- ☐ Specify
☐ Don't know
☐ Prefer not to answer

Number of years:

On average, how many cigarettes do you smoke per day now? (There are 20 cigarettes in a pack.)

- ☐ Specify
☐ Don't know
☐ Prefer not to answer

Number of cigarettes per day:

On average, over the entire time that you smoked, how many cigarettes did you smoke each day? (There are 20 cigarettes in a pack.)

- ☐ Specify
☐ Don't know
☐ Prefer not to answer

Number of cigarettes per day:

In the PAST THREE MONTHS, how often have you used marijuana (cannabis, pot, grass, hash, etc.)?

- ☐ Never
☐ Once or twice
☐ Monthly
☐ Weekly
☐ Daily or almost daily
☐ Prefer not to answer

Have you ever used an electronic nicotine product, even one or two times?
(Electronic nicotine products include e- cigarettes, vape pens, hookah pens, personal vaporizers and mods, e-cigars, e-pipes, and e-hookahs.)

- ☐ Yes
☐ No
☐ Don't know
☐ Prefer not to answer

Do you now use electronic nicotine products?

- ☐ Every day
☐ Some days
☐ Not at all
☐ Don't know
☐ Prefer not to answer

[LEGACY]
Have you been a regular smoker or not within the last 3 years?

- ☐ Yes
☐ No

[LEGACY]
Have you ever smoked regularly (more than a few times a month for at least two months)?
This includes tobacco, cannabis, vapes, e-cigarettes, hookah, or pipes.

- ☐ I've never smoked regularly
☐ I used to smoke
☐ I currently smoke
☐ Prefer not to answer

[LEGACY]
At what age did you start smoking?

[LEGACY]
At what age did you stop?

[LEGACY]
Checklist of different types (choose all that apply):

- ☐ Tobacco cigarettes
☐ Cannabis joints, bong, pipe
☐ Vapes
☐ e-cigarettes
☐ Hookah
☐ Pipes
☐ Other
☐ Prefer not to answer

[LEGACY]

How often do/did you smoke?

- ☐ Multiple times a day
- ☐ About once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ A few times a year
- ☐ Prefer not to answer

[LEGACY]

If you selected "other" for smoking type, please specify: _____

Alcohol consumption

Do you drink alcohol?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

How often do you have at least one drink containing alcohol?

Drinks can be beer, wine, shots of liquor, cocktails containing a shot of liquor

- ☐ Monthly or less
- ☐ 2 - 4 times a month
- ☐ 2 - 3 times a week
- ☐ 4 or more times a week
- ☐ Prefer not to answer

How many drinks containing alcohol do you have on a typical day when you are drinking?

One drink is 12 oz. beer, 5 oz. wine, 1.5 oz. (one shot) liquor

- ☐ 0 - 2
- ☐ 3 - 4
- ☐ 5 - 6
- ☐ 7 - 9
- ☐ 10 or more
- ☐ Prefer not to answer

How often did you have six or more drinks on one occasion in the past year?

- ☐ Never in the past year
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily
- ☐ Prefer not to answer

Have you drunk alcohol today?

- ☐ Yes
- ☐ No

How many drinks did you have? _____

Have you ever been in rehab or counseling for heavy alcohol use?

- ☐ Never in the past year
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily
- ☐ Prefer not to answer

Are you currently in recovery for alcohol use?

- ☐ Yes
- ☐ No

Substance use

How many times in the past YEAR have you used a recreational substance or medication for reasons or in doses other than prescribed?

☐ Yes
☐ No

Recreational substances include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).
More than one

Are you currently in recovery for substance use?

☐ Yes
☐ No

During the past TWO (2) WEEKS, about how often did you use any of the following substances or medications for reasons or in doses other than prescribed?

| | Not at all | One or two days | Several days | More than half the days | Nearly every day |
|--|-----------------------|-----------------------|-----------------------|-------------------------|-----------------------|
| Painkillers (like Vicodin) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stimulants (like Ritalin, Adderall) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Sedatives or tranquilizers (like sleeping pills or Valium) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Marijuana | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cocaine or crack | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Club drugs (like ecstasy) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hallucinogens (like LSD) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Heroin or other opioids, including synthetic opioids like fentanyl | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Inhalants or solvents (like glue) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Methamphetamine (like speed) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Caffeine intake

How many small (8oz or 230ml) cups of coffee OR shots of espresso OR caffeinated teas do you drink on a typical day?

How many small (8oz or 230ml) cups of coffee OR shots of espresso OR caffeinated teas have you had TODAY?

Hydration

How many small (8oz or 230ml) cups of water do you drink on a typical day?

How many small (8oz or 230ml) cups of water have you had TODAY?

Dental problems

Do you have any dental problems that might affect speech?

- ☐ Yes
☐ No

Do you currently have any tooth loss, dentures, retainers or braces?

Allergies or cold symptoms

Do you currently have seasonal allergies, cold-like symptoms or other conditions that may affect your voice today?

- ☐ Yes
☐ No

Check all that apply:

- ☐ Nasal congestion or obstruction
☐ Cough
☐ Scratchy or sore throat
☐ Shortness of breath

Tiredness

How tired are you?

0=not tired at all, 10=extremely tired

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Height and Weight

Height

(inches)

Weight

(lbs)

Unit

- ☐ Metric
☐ US customary units

Symptoms

There are some symptoms that can affect your voice.
Are you currently experiencing any of these symptoms?
Check all that apply.

- ☐ Anxiety or nervousness
- ☐ Confusion
- ☐ Dizziness
- ☐ Frequent or severe headache or migraine
- ☐ Sleep disturbance
- ☐ Speech difficulty
- ☐ Prefer not to answer

Ear, Nose, Throat Medical History

Do you have any of these voice, communication, or hearing conditions? (check all that apply)

| | |
|--------|--|
| Ear | <input type="checkbox"/> Chronic ear infection <input type="checkbox"/> Cochlear implant <input type="checkbox"/> Hearing loss |
| Nose | <input type="checkbox"/> Frequent sinusitis |
| Throat | <input type="checkbox"/> Pre-cancerous throat lesion (e.g. laryngeal leukoplakia or keratosis) <input type="checkbox"/> Reflux (heartburn) <input type="checkbox"/> Reinke's edema, polypoid corditis, or smoker's larynx <input type="checkbox"/> Sjögren's syndrome <input type="checkbox"/> Swallowing disorders (dysphagia) <input type="checkbox"/> Throat cancer <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Velopharyngeal insufficiency <input type="checkbox"/> Vocal fold dysfunction, paradoxical vocal fold motion, or inducible laryngeal obstruction <input type="checkbox"/> Vocal fold polyp, nodule, or cyst <input type="checkbox"/> Vocal hemorrhage or bleed <input type="checkbox"/> Voice/throat disorder |
| Head | <input type="checkbox"/> Radiation around head and neck <input type="checkbox"/> Seasonal allergies |

Have you had any of the interventions mentioned below? (check all that apply)

| | |
|--------|--|
| Ear | <input type="checkbox"/> Chronic ear surgery (e.g. mastoid) <input type="checkbox"/> Ear tubes |
| Nose | <input type="checkbox"/> Septoplasty/Rhinoplasty <input type="checkbox"/> Sinus surgery |
| Throat | <input type="checkbox"/> Airway surgery <input type="checkbox"/> Throat surgery <input type="checkbox"/> Thyroid surgery <input type="checkbox"/> Tonsillectomy/Adenoidectomy |
| Head | <input type="checkbox"/> Head/Neck cancer (e.g. oropharyngeal cancer) <input type="checkbox"/> Sleep surgery |

Neurological Medical History

**Have you been diagnosed with any of these neurological health conditions by a clinician?
(check all that apply)**

Neurological Medical History

- ☐ Brain tumor
- ☐ Dysarthria
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Traumatic brain injury
- ☐ Other

Do you currently have these conditions or currently experience symptoms as a result of having had these conditions?

- ☐ None ☐ Only some
☐ All

Which ones do you currently have?

Respiratory Conditions

Respiratory Conditions

- ☐ Bronchiectasis
- ☐ Cancer (lung or metastatic)
- ☐ Emphysema
- ☐ Interstitial lung disease (sarcoidosis, pulmonary fibrosis)
- ☐ Pneumothorax or atelectasis (collapsed lung)
- ☐ Pulmonary hypertension
- ☐ Radiation to the chest
- ☐ Tuberculosis

Cancer (lung or metastatic)

- ☐ Lung
- ☐ Metastatic

Have you had COVID recently, or are you currently experiencing the effects of long COVID? (check all that apply)

- ☐ COVID in the past year
- ☐ Long COVID (symptoms persisted at least four weeks after initial infection)

Have you had COVID in the past month?

- ☐ Yes
☐ No

Are you currently using CPAP or supplemental oxygen?
(check all that apply)

- ☐ Active CPAP use
- ☐ On supplemental oxygen

Have you had any of the interventions mentioned below? (check all that apply)

Respiratory medical history

- ☐ Craniofacial or chest wall trauma
- ☐ Previous lobectomy
- ☐ Prior chest/airway surgery
- ☐ Prolonged intubation (more than a week)

Have you been exposed to environmental pollution that may affect your breathing or voice?

- ☐ Yes
☐ No

Are you having difficulty breathing today?

- ☐ Yes
☐ No

Please specify the level of difficulty

- ☐ Slight Difficulty
☐ Moderate Difficulty
☐ Significant Difficulty
-

Are you coughing today?

- ☐ Yes
☐ No
-

What is the severity of your cough?

- ☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10
-

Circulatory and Other Conditions

Have you been diagnosed with any of these circulatory or heart conditions by a clinician? (check all that apply)

- ☐ Atrial fibrillation
☐ Cardiac condition
☐ Chronic pericarditis
☐ Congestive heart failure
☐ Coronary heart disease
☐ Hypertension
-

Cardiac condition

Some other conditions can affect the sound of your voice. Have you been diagnosed with any of these conditions by a clinician? (check all that apply)

- ☐ Chronic kidney disease
☐ Diabetes
☐ Infectious disease
☐ Obesity
☐ Scoliosis
-

Infectious disease

Physical Health

In the past 30 days, how much difficulty did you have in:

| | None | Mild | Moderate | Severe | Extreme or cannot do |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Standing for long periods such as 30 minutes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Taking care of your household responsibilities? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Learning a new task, for example, learning how to get to a new place? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| How much have you been emotionally affected by your health problems? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Concentrating on doing something for ten minutes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Walking a long distance such as a kilometre [or equivalent]? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Washing your whole body? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Getting dressed? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Dealing with people you do not know? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Maintaining a friendship? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Your day-to-day work? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Overall, in the past 30 days, how many days were these difficulties present?

(days)

In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?

(days)

In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?

(days)

Medications

Do you currently take or use any of these medications or substances? Please check all that apply

- ☐ Antibiotics
- ☐ Anti-histamines (allergy medications)
- ☐ Anti-Hypertensive Medications (Blood Pressure Medication)
- ☐ Diuretics (ex: Lasix)
- ☐ Decongestants
- ☐ Muscle relaxants (ex: Baclofen)
- ☐ Hormone use
- ☐ Inhaled corticosteroids
- ☐ Oral steroids
- ☐ Anti-anxiety medications: (ex: Benzodiazepine)
- ☐ Chronic Pain medication
- ☐ Psychotropic/antipsychotic medications (ex: Clozapine)
- ☐ Antidepressants (ex: amitryptiline)
- ☐ Immune suppressors (ex: Methotrexate)
- ☐ Reflux medications (ex: Pantoprazole, Nexium)
- ☐ Anticholinergics (ex: Ventolin)
- ☐ Anticoagulants (blood thinners)
- ☐ Antiepileptic (ex: Phenytoin)

Hormone use

- ☐ Oral contraceptive
- ☐ Hormonal replacement therapy (HRT)
- ☐ Androgenic steroids
- ☐ Other

Chronic Pain medication

- ☐ NSAIDs (ex: Ibuprofen/Advil/Cerebrex)
- ☐ Morphine/Oxycodone
- ☐ Neuro-modulators (ex: Gabapentin, Lyrica)

Gynecological

Do you menstruate?

- ☐ Does not apply
- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

Please explain

- ☐ I am pregnant
- ☐ I have an IUD
- ☐ I have gone through menopause
- ☐ Other

If you selected "other" for menstruate, please specify:

Where in your cycle are you? We ask because this may affect your voice.

- ☐ Menstruating
- ☐ Premenstrual
- ☐ Postmenstrual
- ☐ Prefer not to answer

Voice Activity

Do you do one of these jobs or hobbies that requires using your voice for many hours a day? Check all that apply

- ☐ Bartender
- ☐ Waiter, receptionist
- ☐ Speaking (secretary, call center, attorney, salesperson)
- ☐ Teacher
- ☐ Singer
- ☐ Cheerleading
- ☐ Other

If you selected "other" for voice activity, please specify:

How many hours per day do you do this activity with a loud voice or in a loud environment that requires elevating your voice (for instance, a noisy bar or a noisy classroom)?

_____ (hours)

Reading Activity

How good do you think you are at reading out loud in [English/Spanish/French], that is reading out loud without making mistakes and understanding what you read at a normal rate?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor