

Additional file 1 – Items used to determine the status of potential asthmatic subject

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|---|------------------------------|-----------------------------|
| 1. Are you currently taking asthma medication? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. At any time in the last 12 months, have you: | | |
| a) had an asthma attack? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) had wheezing in your chest? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) been woken up with a feeling of tightness in your chest first thing in the morning? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) had an attack of shortness of breath that came on during the day when you were not doing anything strenuous? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) had wheezing in your chest after doing something strenuous? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f) been woken up at night by an attack of shortness of breath? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g) been woken up at night by a coughing fit? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. During your work shift or within the following few hours, do you happen to: | | |
| a) start to cough? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) start having wheezing in your chest when breathing? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) have shortness of breath, a feeling of oppression or tightness in your chest? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |