MEDICAL HISTORY FORM FOR FOLLOW-UP

ID NUMBER:								

FORM CODE: **MHF**
VERSION: 3.0 01/09/2018

Event: _____

0a) Date of Collection ☐☐ / ☐☐ / ☐☐☐☐ 0b) Staff Code ☐☐☐

Instructions: *Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes.*
Notes: *Sub scripts in blue represent the comparable SPIROMICS I variable (i.e. variable $_{5k}$o).*
Sub scripts in red represent the response coding in the SPIROMICS II CDART2 database (i.e. No$_0$)

This questionnaire includes questions about your medical history. This will help us better understand how various medical conditions relate to COPD.

1) Did you get an influenza vaccination (flu shot) in the last 12 months?

☐ No$_0$
☐ Yes$_1$

2a) Did you get a pneumonia vaccination in the last 5 years?

☐ No$_0$ → **Go to 3**
☐ Yes$_1$
☐ Don't know$_2$ → **Go to 3**

2b) If Yes, which vaccination did you receive?

☐ Pneumovax (PSV-23)$_1$
☐ Provnar (PSV-13)$_2$
☐ Both$_3$
☐ Don't know$_4$

3) Have you been diagnosed with alpha-1 anti-trypsin deficiency?

☐ No$_0$
☐ Yes$_1$
☐ Don't know$_2$

Have you seen a physician or other medical provider for any of the following problems since your last SPIROMICS visit?

4) Eyes, ears, nose, throat	No$_0$	Yes$_1$	If Yes, please explain:
a) Vision problems	☐	☐	4a1)_____
b) Hearing problems	☐	☐	4b1)_____
c) Dizziness	☐	☐	4c1)_____

		No$_0$	Yes$_1$	If Yes, please explain:
d)	Ears ringing	☐	☐	4d1)_____
e)	Sinusitis/rhinitis	☐	☐	4e1)_____
f)	Other	☐	☐	4f1)_____

5) Cardiovascular		No$_0$	Yes$_1$	If Yes, please explain:
a)	High blood pressure	☐	☐	5a1)_____
b)	Coronary artery disease	☐	☐	5b1)_____
c)	Angina (chest pain)	☐	☐	5c1)_____
d)	Heart attack	☐	☐	5d1)_____
e)	Murmur	☐	☐	5e1)_____
f)	Palpitations, irregular heartbeat	☐	☐	5f1)_____
g)	Valve disease	☐	☐	5g1)_____
h)	Congestive heart failure	☐	☐	5h1)_____
i)	Blood clots	☐	☐	5i1)_____
j)	Poor circulation (claudication)	☐	☐	5j1)_____
k)	Heart surgery for valve replacement	☐	☐	5k1)_____
l)	Heart surgery for bypass	☐	☐	5l1)_____
m)	Heart procedure for blockage (stent or balloon)	☐	☐	5l1)_____
n)	Heart procedure for pacemaker or abnormal heart rhythm	☐	☐	5n1)_____
5k o)	Other	☐	☐	5k1 5o1)_____

6) Gastrointestinal		No$_0$	Yes$_1$	If Yes, please explain:
a)	Esophageal condition or disease	☐	☐	6a1)_____
b)	Ulcers	☐	☐	6b1)_____
c)	Hepatitis or jaundice	☐	☐	6c1)_____
d)	Crohn's disease or colitis	☐	☐	6d1)_____
e)	Gallstones	☐	☐	6e1)_____
f)	Cirrhosis	☐	☐	6f1)_____
g)	GERD (heart burn)	☐	☐	6g1)_____
h)	Hiatal hernia	☐	☐	6h1)_____
i)	Other	☐	☐	6i1)_____

		No$_0$	Yes$_1$	If Yes, please explain:
7)	Pulmonary/vascular			
a)	Intubation or respirator	☐	☐	7a1)_____
b)	Pneumothorax (collapsed lung)	☐	☐	7b1)_____
c)	Tuberculosis	☐	☐	7c1)_____
d)	Pulmonary fibrosis	☐	☐	7d1)_____
e)	Lung nodules	☐	☐	7e1)_____
f)	Pulmonary embolism or blood clot in lung	☐	☐	7f1)_____
7h g)	Wedge Resection (surgery to remove part or all of the lung)	☐	☐	7h1 7g1)_____
h)	Biopsy of lung with surgery or procedure	☐	☐	7h1)_____
7g i)	Other	☐	☐	7g1 7i1)_____

		No$_0$	Yes$_1$	If Yes, please explain:
8)	Oncology/hematology			
a)	Cancer (except basal cell skin cancer)	☐	☐	8a1)_____
b)	Anemia	☐	☐	8b1)_____
c)	Other	☐	☐	8c1)_____

		No$_0$	Yes$_1$	If Yes, please explain:
9)	Genitourinary and reproductive			
a)	Menstrual symptoms	☐	☐	9a1)_____
b)	Enlarged prostate or BPH (men)	☐	☐	9b1)_____
c)	Bladder or kidney problems/ kidney stones	☐	☐	9c1)_____
d)	Other	☐	☐	9d1)_____

		No$_0$	Yes$_1$	If Yes, please explain:
10)	Endocrine			
a)	Diabetes	☐	☐	10a1)_____
b)	Thyroid	☐	☐	10b1)_____
c)	Other	☐	☐	10c1)_____

		No$_0$	Yes$_1$	If Yes, please explain:
11)	Neurology			
a)	Stroke	☐	☐	11a1)_____
b)	Headaches	☐	☐	11b1)_____
c)	Seizure	☐	☐	11c1)_____
d)	Other	☐	☐	11d1)_____

12) Muscular/skeletal	No$_0$	Yes$_1$	If Yes, please explain:
a) Rheumatoid arthritis	☐	☐	12a1)_____
b) Gout	☐	☐	12b1)_____
c) Osteoporosis	☐	☐	12c1)_____
d) Fractures	☐	☐	12d1)_____
e) Joint pain	☐	☐	12e1)_____
f) Osteoarthritis	☐	☐	12f1)_____
g) Other	☐	☐	12g1)_____

13) Dermatology	No$_0$	Yes$_1$	If Yes, please explain:
a) Rashes/hives/eczema	☐	☐	13a1)_____
b) Psoriasis	☐	☐	13b1)_____
c) Shingles	☐	☐	13c1)_____
d) Other	☐	☐	13d1)_____

14) Infectious disease	No$_0$	Yes$_1$	If Yes, please explain:
a) Atypical mycobacteria (MAC, MAI)	☐	☐	14a1)_____
b) Fungal disease	☐	☐	14b1)_____
c) Other	☐	☐	14c1)_____

15) Psychiatric	No$_0$	Yes$_1$	If Yes, please explain:
a) Anxiety	☐	☐	15a1)_____
b) Depression	☐	☐	15b1)_____
c) Other	☐	☐	15c1)_____

16) Other significant problems not reported in questions 4 -15	No$_0$	Yes$_1$	If Yes, please list:
	☐	☐	16a1) _____
			16b1) _____
			16c1) _____
			16d1) _____
			16e1) _____

Questions 17-23 have been removed.

Now I am going to ask you some questions about your use of alcoholic beverages during the past year. By alcoholic beverages I mean beer, wine, vodka etc.

24a) How often do you have a drink containing alcohol?

- ☐ Never$_0$ → **Go to 32a**
- ☐ Monthly or less$_1$
- ☐ 2 to 4 times per month$_2$
- ☐ 2 to 3 times per week$_3$
- ☐ 4 or more times per week$_4$

25a) How many drinks containing alcohol do you have on a typical day when you are drinking?

- ☐ 1 or 2$_0$
- ☐ 3 or 4$_1$
- ☐ 5 or 6$_2$
- ☐ 7, 8, or 9$_3$
- ☐ 10 or more$_4$

26a) How often do you have six or more drinks on one occasion?

- ☐ Never$_0$
- ☐ Less than monthly$_1$
- ☐ Monthly$_2$
- ☐ Weekly$_3$
- ☐ Daily or almost daily$_4$

→ **If the Total Score for 25a and 26a = 0, Go to 32a**

27a) How often during the last year have you found that you were not able to stop drinking once you had started?

- ☐ Never$_0$
- ☐ Less than monthly$_1$
- ☐ Monthly$_2$
- ☐ Weekly$_3$
- ☐ Daily or almost daily$_4$

28a) How often during the last year have you failed to do what was normally expected from you because of drinking?

- ☐ Never$_0$
- ☐ Less than monthly$_1$
- ☐ Monthly$_2$
- ☐ Weekly$_3$
- ☐ Daily or almost daily$_4$

29a) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- ☐ Never$_0$

- ☐ Less than monthly$_1$
- ☐ Monthly$_2$
- ☐ Weekly$_3$
- ☐ Daily or almost daily$_4$

30a) How often during the last year have you had a feeling of guilt or remorse after drinking?

- ☐ Never$_0$
- ☐ Less than monthly$_1$
- ☐ Monthly$_2$
- ☐ Weekly$_3$
- ☐ Daily or almost daily$_4$

31) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- ☐ Never$_0$
- ☐ Less than monthly$_1$
- ☐ Monthly$_2$
- ☐ Weekly$_3$
- ☐ Daily or almost daily$_4$

32a) Have you or someone else been injured as a result of your drinking?

- ☐ No$_0$
- ☐ Yes, but not in the last year$_2$
- ☐ Yes, during the last year$_4$

33) Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

- ☐ No$_0$
- ☐ Yes, but not in the last year$_2$
- ☐ Yes, during the last year$_4$

→ **IF participant is MALE, Go to End**

→ **IF participant is FEMALE, Continue with 34**

34) Have you reached menopause?

- ☐ No$_0$
- ☐ Yes$_1$
- ☐ Don't know$_2$

Question 35 has been removed.

36) Did you ever use oral contraceptive medications?

☐ No$_0$ → **Go to 38**
☐ Yes$_1$

37) If you did use oral contraceptives, for how many years? ☐☐ years

38) Did you ever use hormone replacement therapy?

☐ No$_0$ → **Go to 43**
☐ Yes$_1$

39) If you did use hormone replacement therapy, for how many years? ☐☐ years

Questions 40-42 have been removed.

43) In the last 12 months have you had an ovary removed?

☐ No$_0$ → **Go to End**
☐ Yes$_1$

44) If you had an ovary removed, was one removed or both?

☐ One$_1$
☐ Both$_2$

45) At what age was your ovary or ovaries removed? ☐☐ years old

END OF FORM