INSTRUCTIONS FOR REVISED RESPIRATORY MEDICATION USE QUESTIONNAIRE RRM, VERSION 1.0, QUESTION BY QUESTION (QxQ)

I. GENERAL INSTRUCTIONS

The Revised Respiratory Medication Use Questionnaire form is completed during the participant's clinic visit.
Please complete at Clinic Visit 5.

Header Information: The header information consists of key fields which uniquely identify each recorded instance of a form. For the Event field, record if this is happening at Visit 5 or another event.

0a. Date of Collection: Record the date the data was collected or abstracted. Select the date from the pop-up calendar in the data management system (DMS) or type the date in the space provided. Dates should be entered in the mm/dd/yyyy format.

0b. Staff Code: Record the SPIROMICS staff code of the person who collected or abstracted the data. This code is assigned to each person at each site by the GIC. If you do not have a staff code and are collecting SPIROMICS data, please contact the GIC in order to receive your own individual staff code.

II. DETAILED INSTRUCTIONS FOR EACH ITEM

Item 1. **Regular Use of Inhaled Medications** Select only one option among the two possible choices.

- Select No if the subject reports not regularly using (at least on one day) any inhaled medications. **[Go to 2.]**
- Select Yes if the subject reports regularly using (at least on one day) any inhaled medications.

Item 1a-z2. **Inhaled Medications.** If Yes to Item 1, check all inhaled medications that apply.

Item 1z2a. **Specify**. If other in Item 1z2, please specify the inhaled medications that the subject reported using.

Item 2. **Regular Use of Nebulized Medications** Select only one option among the two possible choices.

- Select No if the subject reports not regularly using (at least on one day) any inhaled medications. **[Go to 3.]**
- Select Yes if the subject reports regularly using (at least on one day) any inhaled medications.

Item 2a. **Frequency of Nebulized Medication Use** Select only one option among the two possible choices.

- Select daily if the subject reports using nebulized medication daily.
- Select as needed when having difficulties if the subject reports using nebulized medication as needed when having difficulties.

Items 2b1-2b10. **Inhaled medications** Indicate which inhaled medication(s) the subject reported regularly using (check all that apply).

Item 2b10a. **Specify**. If other in Item 2b10, please specify the inhaled medications that the subject reported using.

Item 3. **Regular Use of Oral Medications** Select only one option among the two possible choices.

- Select No if the subject reports not regularly using (at least on one day) any oral medications. **[Go to 4.]**
- Select Yes if the subject reports regularly using (at least on one day) any oral medications listed.

Items 3a-3d. **Inhaled medications** Indicate which oral medication(s) the subject reported regularly using (check all that apply).

Item 4. **Current Use of Oral Corticosteroids** Select only one option among the two possible choices.

- Select No if the subject reports not regularly using (at least on one day) any oral corticosteroids. **[Go to 5.]**
- Select Yes if the subject reports regularly using (at least on one day) any oral corticosteroids.

Items 4a. **How long** Record how long the subject reports using oral corticosteroids in years and days.

Item 5. **Regular Use of Nasal Sprays** Select only one option among the two possible choices.

- Select No if the subject reports not regularly using (at least on one day) any nasal sprays. [Go to 6.]
- Select Yes if the subject reports regularly using (at least on one day) any nasal sprays.

Items 5a-3c. **Nasal sprays** Indicate which nasal spray(s) the subject reported regularly using (check all that apply).

Item 6. **Current Use of Supplemental Oxygen** Select only one option among the two possible choices.

- Select No if the subject reports not currently using (at least on one day) supplemental oxygen (prescribed by a doctor). **[Go to 7.]**
- Select Yes if the subject reports currently using (at least on one day) supplemental oxygen.

Items 6a. **How long** Record how long the subject reports using supplemental oxygen in a 24-hour period in hours.

Item 6b. **Current Use of Nighttime Supplemental Oxygen** Select only one option among the two possible choices.

- Select No if the subject does not report currently using nighttime supplemental oxygen only at night.
- Select Yes if the subject reports currently using nighttime supplemental oxygen only at night.

Item 7. **Current Use of Statin Medications** Select only one option among the two possible choices.

- Select No if the subject reports not currently using (at least on one day) any statin medication. **[Go to 8.]**
- Select Yes if the subject reports regularly using (at least on one day) any statin medication.

Items 7a. **Statin medication** If the response to Item 7 is Yes. Indicate which statin medication the subject reported currently using from the list provided.

Item 7a1. **Specify Other** If the response to Item 7a is Other, record the name of the statin medication the subject reported currently using.

Item 8. **Current Use of Beta-blocker Medications** Select only one option among the two possible choices.

- Select No if the subject reports not currently using (at least on one day) any beta-blocker medication. **[Go to 9.]**
- Select Yes if the subject reports regularly using (at least on one day) any beta-blocker medication.

Items 8a. **Beta-blocker medication** If the response to Item 8 is Yes. Indicate which beta-blocker medication the subject reported currently using from the list provided.

Item 8a1. **Specify Other** If the response to Item 8a is Other, record the name of the beta-blocker medication the subject reported currently using.

Item 9. **Current Use of Oral anti-oxidant supplements Medications** Select only one option among the two possible choices.

- Select No if the subject reports not currently using (at least on one day) any oral anti-oxidant supplements medication. **[Go to 10.]**
- Select Yes if the subject reports regularly using (at least on one day) any oral anti-oxidant supplements medication.

Items 9a-h. **Oral anti-oxidant supplements medication** If the response to Item 9 is Yes, indicate which oral anti-oxidant supplements medication the subject reported currently using from the list provided. (Check all that apply.)

Item 9h1. **Specify Other** If Item 9h is checked, record the name of the oral anti-oxidant supplements medication the subject reported currently using.

Item 10. **Current Use of Aspirin** Select only one option among the two possible choices.

- Select No if the subject reports not currently using (at least on one day) any aspirin or other anticoagulants. **[Go to 11.]**
- Select Yes if the subject reports regularly using (at least on one day) any aspirin or other anticoagulants.

Items 10a-d. **Aspirin or other anticoagulants** If the response to Item 10 is Yes, indicate which aspirin or other anticoagulants the subject reported currently using from the list provided.

Item 11. **Current Use of Nicotine Replacement Therapy** Select only one option among the three possible choices.

- Select No, have never used if the subject reports never having used any nicotine replacement therapy.
- Select Yes, currently using if the subject reports currently using any nicotine replacement therapy.
- Select Yes, have used in the past, but not currently using if the subject reports not currently using any nicotine replacement therapy, but did use them in the past.

Item 12. **Current Use of Prescription Medication for Tobacco Cessation** Select only one option among the four possible choices.

- Select No, have never used if the subject reports never having used any prescription medication for tobacco cessation.
- Select Yes, have used in the past, but not currently using if the subject reports not currently using any prescription medication for tobacco cessation, but did use them in the past.
- Select Yes, currently using Chantix (varenicline) if the subject reports currently using Chantix (varenicline) for tobacco cessation.
- Select Yes, currently using Zyban (bupropion) if the subject reports currently using Zyban (bupropion) for tobacco cessation.

Item 13. **Current or Previous Use of Other Medications** Select only one option among the two possible choices.

- Select No if the subject reports not currently using and have never used any other medications in the last 3 months. **[Go to 14.]**
- Select Yes if the subject reports currently using or having used in the past any other medications in the last 3 months.

Items 13a-i. **Other Medications** If the response to Item 13 is Yes, record any other medications that the subject reported using in the last 3 months in the text boxes provided. Please report name of medication only. Dose and frequency information is not needed.

Item 14. **Current or Previous Use of Other Supplements** Select only one option among the two possible choices.

- Select No if the subject reports not currently using and have never used any other supplements in the last 3 months. **[End form.]**
- Select Yes if the subject reports currently using or having used in the past any other supplements in the last 3 months.

Items 14a-i. **Other Supplements** If the response to Item 14 is Yes, record any other supplements that the subject reported using in the last 4 months in the text boxes provided. Please report name of medication only. Dose and frequency information is not needed.

Save and close the form.