





ID NUMBER:

FORM CODE: BCW  
VERSION: 2.0 6/10/14

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**PRE-BRONCHOSCOPY PULMONARY FUNCTION**

5. Pre-bronchodilator FEV<sub>1</sub> (reported/best): ..... .  **BCW5**  
L-BTPS
6. Post-bronchodilator (4 puffs albuterol) FEV<sub>1</sub> (reported/best): ..... .  **BCW6**  
L-BTPS

**BLOOD COLLECTION:**

7. Date of blood collection: .....  /  /  **BCW7**  
m m / d d / y y y y
8. Collection time: .....  :  AM / PM **BCW8** **BCW8A**  
h h : m m (Circle One)
9. Number of venipuncture attempts: .....  **BCW9**
10. Any blood drawing incidents or problems? (Y/N) .....  **BCW10**
11. Blood drawing incidents: Document problems with venipuncture below. Place an "X" in box(es) corresponding to the tubes in which the blood drawing problem(s) occurred. If a problem other than those listed occurred, use Item 8.

- a. Sample not drawn (Y/N) .....  **BCW11A**
- b. Partial sample drawn (Y/N) .....  **BCW11B**
- c. Tourniquet reapplied (Y/N) .....  **BCW11C**
- d. Fist clenching (Y/N) .....  **BCW11D**
- e. Needle movement(Y/N) .....  **BCW11E**
- f. Participant reclining(Y/N) .....  **BCW11F**
- g. Sample re-drawn(Y/N) .....  **BCW11G**

12. If any other blood drawing problems not listed above (e.g., fasting status, etc.), describe incident or problem here:  
**BCW12**

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13. Phlebotomist's code number: .....  **BCW13**

**ORAL RINSE**

14. Was the tongue scraping collected? (Y/N) .....  **BCW14**
15. Collection time: .....  :  AM / PM **BCW15** **BCW15A**  
h h : m m (Circle One)

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16. Was the oral rinse collected? (Y/N) .....  **BCW16**

17. Collection time: .....  :  AM / PM **BCW17A**  
h h : m m **(Circle One)**

18a. Was the time between oral rinse and bronchoscopy more than 60 minutes? (Y/N) ..  **BCW18A**

18b. If yes, was an additional tongue scraping collected? (Y/N) .....  **BCW18B**

**PROCEDURES:**

**BRONCHOSCOPY**

19. Saline Control Samples

a. Sterile Saline Sample Collected? (Y/N) .....  **BCW19A\_V2**

b. Scope Saline Sample Collected? (Y/N) .....  **BCW19B\_V2**

20. Protected Brush Specimen (X3 in lower lobe):

a. Lobe **BCW19A** \_\_\_\_\_

b. Number collected .....  **BCW19B**

21. Airway wash (Combined data for first and second wash)

a. Lobe: **BCW20A** \_\_\_\_\_

b. Infused:  mL **BCW20B** c. Return:  .  mL **BCW20C**

22. Bronchial alveolar lavage (Combined data on both BALs)

a. Lobe: **BCW21A** \_\_\_\_\_

b. Infused:  mL **BCW21B** c. Return:  .  mL **BCW21C**

d. Collection time: .....  :  AM / PM **BCW21E**  
h h : m m **(Circle One)**

*NOTE: If less than 15cc of fluid is returned from the combined volume of the 20cc wash and the 2x40cc lavage, then the 1x50cc lavage should not be performed.*



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23. Cytological brushings (X3 in ipsilateral lower lobe)

a. Lobe:

b. Number of brushes collected: .....

24. Small airway epithelial brushings (optional)

a. Small airways brush samples collected? (Y/N) .....

b. Lobe:

c. Number of brushes collected: .....

**Endobronchial biopsy collected (X8 in contralateral lung, using all lobes if possible)**

25. Side .....    
Left ..... 0  
Right ..... 1

26. Biopsies:

- a. Biopsy 1: Snap Freeze (Y/N) .....
- b. Biopsy 2: Formalin (Y/N) .....
- c. Biopsy 3: Formalin (Y/N) .....
- d. Biopsy 4: Formalin (Y/N) .....
- e. Biopsy 5: Formalin (Y/N) .....
- f. Biopsy 6: Snap Freeze (Y/N) .....
- g. Biopsy 7: Formalin (Y/N) .....
- h. Biopsy 8: Formalin (Y/N) .....

27a. Lidocaine: 1%   mg    b. 2%  mg     c. 4%  mg

28. Comments:

**PRE-BRONCHOSCOPY PULMONARY FUNCTION**

29. Pre-bronchodilator FEV<sub>1</sub> (reported/best): .....  .  L-BTPS

30. Did you administer additional albuterol? (Y/N) .....

31. How many micrograms? .....  ug

32. Post-bronchodilator (4 puffs albuterol) FEV<sub>1</sub> (reported/best) : .....  .  L-BTPS

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33. Did you administer additional albuterol? (Y/N) .....  **BCW31**
34. How many micrograms? .....  ug **BCW32**
35. Additional FEV<sub>1</sub> values after additional albuterol (reported/best) : ..... . L-BTPS **BCW33**

**POST-BRONCHOSCOPY STATUS**

36. Did the participant experience any adverse events during the bronchoscopy? (Y/N).....  **BCW34**
37. Did the participant need to be admitted for overnight observation post bronchoscopy? (Y/N).....  **BCW35**

**38. CONDITION ON DISCHARGE:**

- a. No chest discomfort complaints (Y/N).....  **BCW36A**
- b. Alert / responsive (Y/N).....  **BCW36B**
- c. Oriented to time, person, place (Y/N).....  **BCW36C**
- d. Heart rate < 100/min (Y/N) .....  **BCW36D**
- e. Ambulate w/o difficulty (Y/N).....  **BCW36E**
- f. Sips water w/o cough/difficulty (Y/N).....  **BCW36F**
- g. FEV<sub>1</sub> > 90% of the pre-BD baseline FEV<sub>1</sub> (Y/N)..  **BCW36G**

39. Comments: **BCW37** \_\_\_\_\_  
\_\_\_\_\_

40. Coordinator Signature and Date: \_\_\_\_\_



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**PRE-BRONCHOSCOPY PULMONARY FUNCTION**

5. Pre-bronchodilator FEV<sub>1</sub> (reported/best): .....  .   **BCW5** L-BTPS

6. Post-bronchodilator (4 puffs albuterol) FEV<sub>1</sub> (reported/best): .....  .   **BCW6** L-BTPS

**BLOOD COLLECTION:**

7. Date of blood collection:.....   /   /     **BCW7**  
m m / d d / y y y y

8. Collection time: .....   :   AM / PM **BCW8A**  
h h : m m **(Circle One)**

9. Number of venipuncture attempts: .....  **BCW9**

10. Any blood drawing incidents or problems? (Y/N).....  **BCW10**

11. Blood drawing incidents: Document problems with venipuncture below. Place an "X" in box(es) corresponding to the tubes in which the blood drawing problem(s) occurred. If a problem other than those listed occurred, use Item 8.

- a. Sample not drawn (Y/N) .....  **BCW11A**
- b. Partial sample drawn (Y/N) .....  **BCW11B**
- c. Tourniquet reapplied (Y/N) .....  **BCW11C**
- d. Fist clenching (Y/N).....  **BCW11D**
- e. Needle movement(Y/N) .....  **BCW11E**
- f. Participant reclining(Y/N) .....  **BCW11F**
- g. Sample re-drawn(Y/N) .....  **BCW11G**

12. If any other blood drawing problems not listed above (e.g., fasting status, etc.), describe incident or problem here:  
**BCW12**

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13. Phlebotomist's code number: .....    **BCW13**

**ORAL RINSE**

14. Was the tongue scraping collected? (Y/N) .....  **BCW14**

15. Collection time: .....   :   AM / PM **BCW15A**  
h h : m m **(Circle One)**

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16. Was the oral rinse collected? (Y/N) .....  **BCW16**

17. Collection time: .....     :   AM / PM **BCW17A**  
h h : m m **(Circle One)**

18a. Was the time between oral rinse and bronchoscopy more than 60 minutes? (Y/N) ...  **BCW18A**

18b. If yes, was an additional tongue scraping collected? (Y/N) .....  **BCW18B**

**PROCEDURES:**

**BRONCHOSCOPY**

19. Protected Brush Specimen (X3 in lower lobe):

a. Lobe **BCW19A** \_\_\_\_\_

b. Number collected .....  **BCW19B**

20. Airway wash (Combined data for first and second wash)

a. Lobe: **BCW20A** \_\_\_\_\_

b. Infused:   mL **BCW20B** c. Return:   .  mL **BCW20C**

21. Bronchial alveolar lavage (Combined data on both BALs)

a. Lobe: **BCW21A** \_\_\_\_\_

b. Infused:    mL **BCW21B** c. Return:    .  mL **BCW21C**

d. Collection time: .....     :   AM / PM **BCW21E**  
h h : m m **(Circle One)**

22. Cytological brushings (X3 in ipsilateral lower lobe)

a. Lobe: **BCW22A** \_\_\_\_\_

b. Number of brushes collected: .....  **BCW22B**

**Endobronchial biopsy collected (X8 in contralateral lung, using all lobes if possible)**

23. Side .....  **BCW23**

Left ..... 0  
Right ..... 1

24. Biopsies:

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- a. Biopsy 1: Snap Freeze (Y/N) .....  **BCW24A**
- b. Biopsy 2: Formalin (Y/N) .....  **BCW24B**
- c. Biopsy 3: Formalin (Y/N) .....  **BCW24C**
- d. Biopsy 4: Formalin (Y/N) .....  **BCW24D**
- e. Biopsy 5: Formalin (Y/N) .....  **BCW24E**
- f. Biopsy 6: Snap Freeze (Y/N) .....  **BCW24F**
- g. Biopsy 7: Formalin (Y/N) .....  **BCW24G**
- h. Biopsy 8: Formalin (Y/N) .....  **BCW24H**

25a. Lidocaine: 1%  **BCW25A** mg      b. 2%  **BCW25B** mg      c. 4%  **BCW25C** mg

26. Comments: **BCW26** \_\_\_\_\_

**POST-BRONCHOSCOPY PULMONARY FUNCTION**

- 27. Pre-bronchodilator FEV<sub>1</sub> (reported/best): ..... . **BCW27** L-BTPS
- 28. Did you administer additional albuterol? (Y/N) .....  **BCW28**
- 29. How many micrograms? .....  ug **BCW29**
- 30. Post-bronchodilator (4 puffs albuterol) FEV<sub>1</sub> (reported/best) : ..... . **BCW30** L-BTPS
- 31. Did you administer additional albuterol? (Y/N) .....  **BCW31**
- 32. How many micrograms? .....  ug **BCW32**
- 33. Additional FEV<sub>1</sub> values after additional albuterol (reported/best) : ..... . **BCW33** L-BTPS

**POST-BRONCHOSCOPY STATUS**

- 34. Did the participant experience any adverse events during the bronchoscopy? (Y/N) .....  **BCW34**
- 35. Did the participant need to be admitted for overnight observation post bronchoscopy? (Y/N) .....  **BCW35**

**36. CONDITION ON DISCHARGE:**

- a. No chest discomfort complaints (Y/N) .....  **BCW36A**
- b. Alert / responsive (Y/N) .....  **BCW36B**

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- c. Oriented to time, person, place (Y/N).....  BCW36C
- d. Heart rate < 100/min (Y/N).....  BCW36D
- e. Ambulate w/o difficulty (Y/N) .....  BCW36E
- f. Sips water w/o cough/difficulty (Y/N).....  BCW36F
- g. FEV1 > 90% of the pre-BD baseline FEV1 (Y/N)..  BCW36G

37. Comments: BCW37 \_\_\_\_\_  
\_\_\_\_\_

38. Coordinator Signature and Date: \_\_\_\_\_





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- 3f2) Additional steroids .....  BEQ03F2
- 3f3) Don't know .....  BEQ03F3
- 3f4) Don't remember.....  BEQ03F4
- 3g) Were you admitted to the hospital? .....  BEQ03G
- 4) (do not ask) Did the participant have a second episode? .....  → **if no, skip to end** BEQ04
- 5) For the second episode of breathing problems you had in the last 12 months:
- 5a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  BEQ05A
- 5b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  BEQ05B
- 5c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N).....  BEQ05C
- 5d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  BEQ05D
- 5e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  BEQ05E
- During that visit were you given (check all that apply):
- 5e1) An additional antibiotic .....  BEQ05E1
- 5e2) Additional steroids .....  BEQ05E2
- 5e3) Don't know .....  BEQ05E3
- 5e4) Don't remember.....  BEQ05E4
- 5f) Were you evaluated in an Emergency Department? .....  BEQ05F
- During that visit were you given (check all that apply):
- 5f1) An additional antibiotic .....  BEQ05F1
- 5f2) Additional steroids .....  BEQ05F2
- 5f3) Don't know .....  BEQ05F3
- 5f4) Don't remember.....  BEQ05F4
- 5g) Were you admitted to the hospital? .....  BEQ05G
- 6) (do not ask) Did the participant have a third episode? .....  → **if no, skip to end** BEQ06

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7) For the third episode of breathing problems you had in the last 12 months:

7a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **BEQ07A**

7b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  **BEQ07B**

7c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N).....  **BEQ07C**

7d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **BEQ07D**

7e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **BEQ07E**

During that visit were you given (check all that apply):

7e1) An additional antibiotic .....  **BEQ07E1**

7e2) Additional steroids .....  **BEQ07E2**

7e3) Don't know .....  **BEQ07E3**

7e4) Don't remember.....  **BEQ07E4**

7f) Were you evaluated in an Emergency Department? .....  **BEQ07F**

During that visit were you given (check all that apply):

7f1) An additional antibiotic .....  **BEQ07F1**

7f2) Additional steroids .....  **BEQ07F2**

7f3) Don't know .....  **BEQ07F3**

7f4) Don't remember.....  **BEQ07F4**

7g) Were you admitted to the hospital? .....  **BEQ07G**

8) (do not ask) Did the participant have a fourth episode? .....  → **if no, skip to end** **BEQ08**

9) For the fourth episode of breathing problems you had in the last 12 months:

9a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **BEQ09A**

9b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  **BEQ09B**

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9c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N).....  BEQ09C

9d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  BEQ09D

9e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  BEQ09E

During that visit were you given (check all that apply):

9e1) An additional antibiotic .....  BEQ09E1

9e2) Additional steroids .....  BEQ09E2

9e3) Don't know .....  BEQ09E3

9e4) Don't remember.....  BEQ09E4

9f) Were you evaluated in an Emergency Department? .....  BEQ09F

During that visit were you given (check all that apply):

9f1) An additional antibiotic .....  BEQ09F1

9f2) Additional steroids .....  BEQ09F2

9f3) Don't know .....  BEQ09F3

9f4) Don't remember.....  BEQ09F4

9g) Were you admitted to the hospital? .....  BEQ09G

10) (do not ask) Did the participant have a fifth episode? .....  **→if no, skip to end** BEQ10

11) For the fifth episode of breathing problems you had in the last 12 months:

11a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N).....  BEQ11A

11b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  BEQ11B

11c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N).....  BEQ11C

11d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  BEQ11D

11e) Were you evaluated in a physician's office or urgent care? (Y/N).....  BEQ11E

During that visit were you given (check all that apply):

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- 11e1) An additional antibiotic .....  BEQ11E1
- 11e2) Additional steroids .....  BEQ11E2
- 11e3) Don't know .....  BEQ11E3
- 11e4) Don't remember .....  BEQ11E4

11f) Were you evaluated in an Emergency Department? .....  BEQ11F

During that visit were you given (check all that apply):

- 11f1) An additional antibiotic .....  BEQ11F1
- 11f2) Additional steroids .....  BEQ11F2
- 11f3) Don't know .....  BEQ11F3
- 11f4) Don't remember .....  BEQ11F4

11g) Were you admitted to the hospital? .....  BEQ11G

12) (do not ask) Did the participant have a sixth episode?.....  → **If no, skip to end** BEQ12

13) For the sixth episode of breathing problems you had in the last 12 months:

13a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  BEQ13A

13b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  BEQ13B

13c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N).....  BEQ13C

13d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  BEQ13D

13e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  BEQ13E

During that visit were you given (check all that apply):

- 13e1) An additional antibiotic .....  BEQ13E1
- 13e2) Additional steroids .....  BEQ13E2
- 13e3) Don't know .....  BEQ13E3
- 13e4) Don't remember .....  BEQ13E4

13f) Were you evaluated in an Emergency Department? .....  BEQ13F

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During that visit were you given (check all that apply):

13f1) An additional antibiotic .....  **BEQ13F1**

13f2) Additional steroids .....  **BEQ13F2**

13f3) Don't know .....  **BEQ13F3**

13f4) Don't remember .....  **BEQ13F4**

13g) Were you admitted to the hospital? .....  **BEQ13G**



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### Blood Processing:

Indicate the time each tube was processed:

#### 10. Tube 1 - Red Top 1 – Serum

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last aliquot:     $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)

#### 11. Tube 2 - Red Top 2 – Serum

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last aliquot:     $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)













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### Blood Processing:

Indicate the time each tube was processed:

#### 10. Tube 1 - Red/Gray Top 1 – Serum-SST

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last four aliquots:      $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)

#### 11. Tube 2 - Red/Gray Top 2 – Serum-SST

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last four aliquots:      $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)

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12. Tube 3 – Yellow Top 1 – Plasma-ACD

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last four aliquots:      $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)

13. Tube 4 – Lavender Top 1 – Plasma-EDTA 10ml

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last four aliquots:      $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)

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14. Tube 5 – Lavender Top 2 – Plasma/cell lysate-EDTA 10ml

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last four aliquots:      $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)

15. Tube 6 – Lavender Top 3 – EDTA 10ml

- a. Time Processed:   AM / PM (Circle One)
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No
- Broken Tube
- Sample re-centrifuged
- Clotted
- Hemolyzed
- Lipemic
- Other
- Specify: \_\_\_\_\_
- c. Number of Aliquots:
- d. Volume in last four aliquots:      $\mu$ L
- e. Freezer box number:
- f. Time aliquots placed in freezer   AM / PM (Circle One)









# BRONCHITIS INDEX SCORING FORM

ID NUMBER:	<b>BLINDID</b>					
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Visit Number	<b>VISIT</b>	SEQ #			
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0a) Form Date: .....   /   /     **BIS0A**      0b) Code .....    **BIS0B**

**Instructions:** This form should be completed during the participant's visit.

1) Erythema .....  **BIS1**

- Normal..... 0
- Light Red..... 1
- Red ..... 2
- Beefy Red ..... 3

2) Edema .....  **BIS2**

- Normal airway..... 0
- Blunting of bifurcations ..... 1
- Airway Narrowing ..... 2
- Airway occluded ..... 3

3) Secretions .....  **BIS3**

- Normal..... 0
- Strands of clear mucus..... 1
- Globules of mucus..... 2
- Airway occluded ..... 3

4) Friability .....  **BIS4**

- Normal..... 0
- Punctate submucosal hemorrhages..... 1
- Linear submucosal hemorrhages..... 2
- Frank bleeding..... 3



# BASELINE MEDICAL HISTORY FORM

ID NUMBER:	<b>BLINDID</b>				
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FORM CODE: **BMH**  
VERSION: **2.0** 7/6/11

Visit Number	<b>VISIT</b>
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SEQ #			
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0a) Form Date .....   /   /

0b) Initials .....

**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.

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

1) Have you had any hospitalizations with in the past 12 months? (Y/N) .....  **BMH01**

If **YES**:

1a) Describe: **BMH01A** \_\_\_\_\_

Approximate date:   /   /     **BMH01A1**

1b) Describe: **BMH01B** \_\_\_\_\_

Approximate date:   /   /     **BMH01B1**

1c) Describe: **BMH01C** \_\_\_\_\_

Approximate date:   /   /     **BMH01C1**

1d) Describe: **BMH01D** \_\_\_\_\_

Approximate date:   /   /     **BMH01D1**

1e) Describe: **BMH01E** \_\_\_\_\_

Approximate date:   /   /     **BMH01E1**

1f) Describe: **BMH01F** \_\_\_\_\_

Approximate date:   /   /     **BMH01F1**

1g) Describe: **BMH01G** \_\_\_\_\_

Approximate date:   /   /     **BMH01G1**

1h) Describe: **BMH01H** \_\_\_\_\_

Approximate date:   /   /     **BMH01H1**

ID NUMBER:									
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FORM CODE: **BMH**  
VERSION: 2.0 7/6/11

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SEQ # 

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2) Have you visited an emergency department or urgent care center in the past 12 months? (Y/N) .....  **BMH02**

If **YES**:

2a) Describe: **BMH02A** \_\_\_\_\_

Approximate date: 

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**BMH02A1**

2b) Describe: **BMH02B** \_\_\_\_\_

Approximate date: 

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**BMH02B1**

2c) Describe: **BMH02C** \_\_\_\_\_

Approximate date: 

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**BMH02C1**

2d) Describe: **BMH02D** \_\_\_\_\_

Approximate date: 

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**BMH02D1**

2e) Describe: **BMH02E** \_\_\_\_\_

Approximate date: 

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**BMH02E1**

2f) Describe: **BMH02F** \_\_\_\_\_

Approximate date: 

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**BMH02F1**

2g) Describe: **BMH02G** \_\_\_\_\_

Approximate date: 

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**BMH02G1**

2h) Describe: **BMH02H** \_\_\_\_\_

Approximate date: 

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**BMH02H1**

2i) Describe: **BMH02I** \_\_\_\_\_

Approximate date: 

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**BMH02I1**

2j) Describe: **BMH02J** \_\_\_\_\_

Approximate date: 

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**BMH02J1**

3) Have you ever had any surgeries (lung, heart, other)? (Y/N) .....  **BMH03**

If **YES**:

3a) Describe: **BMH03A** \_\_\_\_\_

ID NUMBER:							
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FORM CODE: **BMH**  
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Approximate date: 

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**BMH03A1**

3b) Describe: **BMH03B**

Approximate date: 

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**BMH03B1**

3c) Describe: **BMH03C**

Approximate date: 

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**BMH03C1**

3d) Describe: **BMH03D**

Approximate date: 

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**BMH03D1**

3e) Describe: **BMH03E**

Approximate date: 

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**BMH03E1**

3f) Describe: **BMH03F**

Approximate date: 

--	--	--	--	--	--	--	--

**BMH03F1**

3g) Describe: **BMH03G**

Approximate date: 

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**BMH03G1**

3h) Describe: **BMH03H**

Approximate date: 

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**BMH03H1**

3i) Describe: **BMH03I**

Approximate date: 

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**BMH03I1**

3j) Describe: **BMH03J**

Approximate date: 

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**BMH03J1**

4) Do you get an influenza vaccination (flu shot) every year? **BMH04**

Yes → **Go to 4b**

I get a flu shot some years → **Go to 4b**

I've never had a flu shot → **Go to 5**

4b) Did you get an influenza vaccination (flu shot) in the last 12 months? **BMH04B**

Yes

No

ID NUMBER:								
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FORM CODE: **BMH**  
 VERSION: 2.0 7/6/11

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SEQ # 

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5) When was your most recent pneumonia vaccination? (Pneumovax) **BMH05**

- Never had
- Within past 5 years
- More than 5 years ago

6) Have you been diagnosed with alpha-1 anti-trypsin deficiency? **BMH06**

- Yes
- No
- Don't know

**Have you ever seen a physician or other medical provider for any of the following kinds of problems?**

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
7) Eyes, ears, nose, throat			
a) Vision problems <b>BMH07A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07A1</b> _____
b) Hearing problems <b>BMH07B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07B1</b> _____
c) Dizziness <b>BMH07C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07C1</b> _____
d) Ears ringing <b>BMH07D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07D1</b> _____
e) Sinusitis/rhinitis <b>BMH07E</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07E1</b> _____
f) Other <b>BMH07F</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07F1</b> _____

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
8) Cardiovascular			
a) High blood pressure <b>BMH08A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08A1</b> _____
b) Coronary artery disease <b>BMH08B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08B1</b> _____
c) Angina (chest pain) <b>BMH08C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08C1</b> _____
d) Heart attack <b>BMH08D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08D1</b> _____
e) Murmur <b>BMH08E</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08E1</b> _____
f) Palpitations, irregular heartbeat <b>BMH08F</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08F1</b> _____
g) Valve disease <b>BMH08G</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08G1</b> _____
h) Congestive heart failure <b>BMH08H</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08H1</b> _____
i) Blood clots <b>BMH08I</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08I1</b> _____
j) Poor circulation (claudication) <b>BMH08J</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08J1</b> _____
k) Other <b>BMH08K</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08K1</b> _____

ID NUMBER:							
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FORM CODE: **BMH**  
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- 9) Gastrointestinal
- |                                    | <u>Yes</u>  | <u>No</u>                | <u>Explain</u>       |
|------------------------------------|---|--------------------------|----------------------|
| a) Esophageal condition or disease | <input checked="" type="checkbox"/> <b>BMH09A</b> | <input type="checkbox"/> | <b>BMH09A1</b> _____ |
| b) Ulcers                          | <input type="checkbox"/> <b>BMH09B</b>            | <input type="checkbox"/> | <b>BMH09B1</b> _____ |
| c) Hepatitis or jaundice           | <input type="checkbox"/> <b>BMH09C</b>            | <input type="checkbox"/> | <b>BMH09C1</b> _____ |
| d) Crohn's disease or colitis      | <input type="checkbox"/> <b>BMH09D</b>            | <input type="checkbox"/> | <b>BMH09D1</b> _____ |
| e) Gallstones                      | <input type="checkbox"/> <b>BMH09E</b>            | <input type="checkbox"/> | <b>BMH09E1</b> _____ |
| f) Cirrhosis                       | <input type="checkbox"/> <b>BMH09F</b>            | <input type="checkbox"/> | <b>BMH09F1</b> _____ |
| g) GERD (heart burn)               | <input type="checkbox"/> <b>BMH09G</b>            | <input type="checkbox"/> | <b>BMH09G1</b> _____ |
| h) Hiatal hernia                   | <input type="checkbox"/> <b>BMH09H</b>            | <input type="checkbox"/> | <b>BMH09H1</b> _____ |
| i) Other                           | <input type="checkbox"/> <b>BMH09I</b>            | <input type="checkbox"/> | <b>BMH09I1</b> _____ |
- 
- 10) Pulmonary/vascular
- |                                  | <u>Yes</u>  | <u>No</u>                | <u>Explain</u>       |
|----------------------------------|---|--------------------------|----------------------|
| a) Intubation or respirator      | <input checked="" type="checkbox"/> <b>BMH10A</b> | <input type="checkbox"/> | <b>BMH10A1</b> _____ |
| b) Pneumothorax (collapsed lung) | <input type="checkbox"/> <b>BMH10B</b>            | <input type="checkbox"/> | <b>BMH10B1</b> _____ |
| c) Tuberculosis                  | <input type="checkbox"/> <b>BMH10C</b>            | <input type="checkbox"/> | <b>BMH10C1</b> _____ |
| d) Pulmonary fibrosis            | <input type="checkbox"/> <b>BMH10D</b>            | <input type="checkbox"/> | <b>BMH10D1</b> _____ |
| e) Lung nodules                  | <input type="checkbox"/> <b>BMH10E</b>            | <input type="checkbox"/> | <b>BMH10E1</b> _____ |
| f) Pulmonary embolism            | <input type="checkbox"/> <b>BMH10F</b>            | <input type="checkbox"/> | <b>BMH10F1</b> _____ |
| g) Other                         | <input type="checkbox"/> <b>BMH10G</b>            | <input type="checkbox"/> | <b>BMH10G1</b> _____ |
- 
- 11) Oncology/hematology
- |   | <u>Yes</u>  | <u>No</u>                | <u>Explain</u>         |
|---|---|--------------------------|------------------------|
| a) Cancer (except basal cell skin cancer) | <input checked="" type="checkbox"/> <b>BMH11A</b> | <input type="checkbox"/> | <b>BMH11A1</b> _____   |
| b) Anemia                                 | <input type="checkbox"/> <b>BMH11B</b>            | <input type="checkbox"/> | <b>BMH11BEXP</b> _____ |
| c) Other                                  | <input type="checkbox"/> <b>BMH11C</b>            | <input type="checkbox"/> | <b>BMH11C1</b> _____   |
- 
- 12) Genitourinary and reproductive
- |  | <u>Yes</u>  | <u>No</u>                | <u>Explain</u>         |
|--|---|--------------------------|------------------------|
| a) Menstrual symptoms (women)                | <input checked="" type="checkbox"/> <b>BMH12A</b> | <input type="checkbox"/> | <b>BMH12A1</b> _____   |
| b) Enlarged prostate or BPH (men)            | <input type="checkbox"/> <b>BMH12B</b>            | <input type="checkbox"/> | <b>BMH12B1</b> _____   |
| c) Bladder or kidney problems/ kidney stones | <input type="checkbox"/> <b>BMH12C</b>            | <input type="checkbox"/> | <b>BMH12C1</b> _____   |
| d) Other                                     | <input type="checkbox"/> <b>BMH12D</b>            | <input type="checkbox"/> | <b>BMH12DEXP</b> _____ |
- 
- 13) Endocrine
- |             | <u>Yes</u>                             | <u>No</u>                | <u>Explain</u>         |
|-------------|--|--------------------------|------------------------|
| a) Diabetes | <input type="checkbox"/> <b>BMH13A</b> | <input type="checkbox"/> | <b>BMH13A1</b> _____   |
| b) Thyroid  | <input type="checkbox"/> <b>BMH13B</b> | <input type="checkbox"/> | <b>BMH13B1</b> _____   |
| c) Other    | <input type="checkbox"/> <b>BMH13C</b> | <input type="checkbox"/> | <b>BMH13CEXP</b> _____ |

ID NUMBER:							
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FORM CODE: **BMH**  
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14) Neurology

	Yes	No	Explain
a) Stroke <b>BMH14A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14A1</b>
b) Headaches <b>BMH14B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14B1</b>
c) Seizure <b>BMH14C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14C1</b>
d) Other <b>BMH14D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14D1</b>

15) Muscular/skeletal

	Yes	No	Explain
a) Rheumatoid arthritis <b>BMH15A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15A1</b>
b) Gout <b>BMH15B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15B1</b>
	Yes	No	Explain.....
c) Osteoporosis <b>BMH15C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15C1</b>
d) Fractures <b>BMH15D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15D1</b>
e) Joint pain <b>BMH15E</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15E1</b>
f) Osteoarthritis <b>BMH15F</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15F1</b>
g) Other <b>BMH15G</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15G1</b>

16) Dermatology

	Yes	No	Explain
a) Rashes/hives/eczema <b>BMH16A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16A1</b>
b) Psoriasis <b>BMH16B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16BEXP</b>
c) Shingles <b>BMH16C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16C1</b>
d) Other <b>BMH16D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16D1</b>

17) Infectious disease

	Yes	No	Explain
a) Atypical mycobacteria (MAC, MAI) <b>BMH17A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH17A1</b>
b) Fungal disease <b>BMH17B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH17B1</b>
c) Other <b>BMH17C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH17C1</b>

18) Psychiatric

	Yes	No	Explain
a) Anxiety <b>BMH18A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH18A1</b>
b) Depression <b>BMH18B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH18B1</b>
c) Other <b>BMH18C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH18C1</b>

19) Other significant problems not reported in questions 2-18 **BMH19**

	Yes	No	
a)	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH19A</b>
b)	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH19B</b>
c)	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH19C</b>
d)	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH19D</b>
e)	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH19E</b>



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FORM CODE: **BMH**  
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**These next questions refer to recent illnesses or problems you may have had.**

20) In the last two weeks have you had any of the following:

- 20a) A fever, cold, flu, or sore throat? (Y/N) .....  **BMH20A**
- 20b) A urinary tract infection? (Y/N) .....  **BMH20B**
- 20c) Seasonal allergies? (Y/N) .....  **BMH20C**
- 20d) A sinus infection or sinusitis? (Y/N) .....  **BMH20D**
- 20e) A tooth infection? (Y/N) .....  **BMH20E**
- 20f) A flare up of gout? (Y/N) .....  **BMH20F**
- 20g) A flare up of arthritis? (Y/N) .....  **BMH20G**
- 20h) Other? (Y/N) .....  **BMH20H**

20i) Please explain: **BMH20I** \_\_\_\_\_

21) Are you allergic to any medications, latex, food, or substances? (Y/N) .....  **BMH21**

If **YES**:

List substance:	Reaction
a) <b>BMH21A</b>	<b>BMH21A1</b>
b) <b>BMH21B</b>	<b>BMH21B1</b>
c) <b>BMH21C</b>	<b>BMH21C1</b>
d) <b>BMH21D</b>	<b>BMH21D1</b>
e) <b>BMH21E</b>	<b>BMH21E1</b>

ID NUMBER:								
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FORM CODE: **BMH**  
VERSION: **2.0 7/6/11**

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22) In the past 12 months, how often have you consumed any alcohol containing beverage (beer, wine, wine coolers, liquor, or mixed drinks such as margaritas, martinis, or daiquiris)? (check only one) **BMH22**

- Every Day .....
- 4 to 6 days per week .....
- 2 to 3 days per week .....
- Once per week .....
- 1 to 3 times per month .....
- Less than once per month .....
- No alcohol in the past 12 months .....  → **Go to 29**

23) When you drink alcohol containing beverages, how many do you usually drink at one sitting? (check only one) **BMH23**

- 1 or 2 .....
- 3 or 4 .....
- 5 or 6 .....
- More than 6 .....

24) What kind of alcoholic beverages do you usually drink? (check all that apply)

- Beer .....  **BMH24\_1**
- Wine .....  **BMH24\_2**
- Drinks containing liquor .....  **BMH24\_3**

25) How often do you have eight or more drinks on one occasion? **BMH25**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....

26) How often during the last year have you been unable to remember what happened the night before because you had been drinking? **BMH26**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....

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FORM CODE: **BMH**  
VERSION: 2.0 7/6/11

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Number 

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27) How often during the last year have you failed to do what was normally expected of you because of your drinking? **BMH27**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....

28) Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down? **BMH28**

- No .....
- Yes, but not in the last year .....
- Yes in the last year .....

If participant is MALE, skip to 44  
If participant is FEMALE, continue

29) At what age did you begin monthly menstruation (*monthly period*)? ..... 

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 yrs old **BMH29**

30) Have you reach menopause? ..... **BMH30**  
Yes ..... Y  
No ..... N → **Go to 31**  
I don't know ..... U → **Go to 31**

31) If you have reached menopause, at what age did that occur? ..... 

--	--

 yrs old **BMH31**

32) Did you ever use oral contraceptive medications? ..... **BMH32**  
Yes ..... Y  
No ..... N → **Go to 33**

33) If you did use oral contraceptives, for how many years? ..... 

--	--

 years **BMH33**

34) Did you ever use hormone replacement therapy? ..... **BMH34**  
Yes ..... Y  
No ..... N → **Go to 35**

35) If you did use hormone replacement therapy, for how many years? ..... 

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 years **BMH35**

ID NUMBER:								
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FORM CODE: **BMH**  
VERSION: **2.0 7/6/11**

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Number 

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36) Have you ever been pregnant (*include miscarriage, abortions*)? .....  **BMH36**  
Yes ..... Y  
No ..... N → **Go to 40**

37) If you have been pregnant, how old were you at the time of your first pregnancy? .....   **BMH37** yrs old

38) How many times have you been pregnant? .....   **BMH38**

39) Did you ever breastfeed? .....  **BMH39**  
Yes ..... Y  
No ..... N → **Go to 41**

40) If you did breastfeed, for approximately how many total months did you breastfeed  
(*total for all pregnancies*)? .....   **BMH40** months

41) Have you ever had an ovary removed? .....  **BMH41**  
Yes ..... Y  
No ..... N → **Go to END**

42) If you had an ovary removed, was one removed or both? .....  **BMH42**  
One ..... O  
Both ..... B

43) At what age was your ovary or ovaries removed? .....   **BMH43** yrs old



# BASELINE MEDICAL HISTORY FORM

ID NUMBER:	<input type="text" value="BLINDID"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: BMH  
VERSION: 1.0 10/26/10

Visit Number	<input type="text" value="VISIT"/>
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SEQ #	<input type="text"/>	<input type="text"/>	<input type="text"/>
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0a) Form Date .....   /   /

0b) Initials .....

**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.

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

1) Have you had any hospitalizations with in the past 12 months? (Y/N) .....  **BMH01**

If YES:

1a) Describe: **BMH01A** \_\_\_\_\_

Approximate date:   /   /     **BMH01A1**

1b) Describe: **BMH01B** \_\_\_\_\_

Approximate date:   /   /     **BMH01B1**

1c) Describe: **BMH01C** \_\_\_\_\_

Approximate date:   /   /     **BMH01C1**

1d) Describe: **BMH01D** \_\_\_\_\_

Approximate date:   /   /     **BMH01D1**

1e) Describe: **BMH01E** \_\_\_\_\_

Approximate date:   /   /     **BMH01E1**

1f) Describe: **BMH01F** \_\_\_\_\_

Approximate date:   /   /     **BMH01F1**

1g) Describe: **BMH01G** \_\_\_\_\_

Approximate date:   /   /     **BMH01G1**

1h) Describe: **BMH01H** \_\_\_\_\_

Approximate date:   /   /     **BMH01H1**

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2) Have you visited an emergency department or urgent care center in the past 12 months? (Y/N) .....  **BMH02**

If **YES**:

2a) Describe: **BMH02A** \_\_\_\_\_

Approximate date: 

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**BMH02A1**

2b) Describe: **BMH02B** \_\_\_\_\_

Approximate date: 

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**BMH02B1**

2c) Describe: **BMH02C** \_\_\_\_\_

Approximate date: 

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**BMH02C1**

2d) Describe: **BMH02D** \_\_\_\_\_

Approximate date: 

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**BMH02D1**

2e) Describe: **BMH02E** \_\_\_\_\_

Approximate date: 

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**BMH02E1**

2f) Describe: **BMH02F** \_\_\_\_\_

Approximate date: 

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**BMH02F1**

2g) Describe: **BMH02G** \_\_\_\_\_

Approximate date: 

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**BMH02G1**

2h) Describe: **BMH02H** \_\_\_\_\_

Approximate date: 

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**BMH02H1**

2i) Describe: **BMH02I** \_\_\_\_\_

Approximate date: 

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**BMH02I1**

2j) Describe: **BMH02J** \_\_\_\_\_

Approximate date: 

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**BMH02J1**

3) Have you ever had any surgeries (lung, heart, other)? (Y/N) .....  **BMH03**

If **YES**:

3a) Describe: **BMH03A** \_\_\_\_\_

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Approximate date: 

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**BMH03A1**

3b) Describe: **BMH03B** \_\_\_\_\_

Approximate date: 

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**BMH03B1**

3c) Describe: **BMH03C** \_\_\_\_\_

Approximate date: 

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**BMH03C1**

3d) Describe: **BMH03D** \_\_\_\_\_

Approximate date: 

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**BMH03D1**

3e) Describe: **BMH03E** \_\_\_\_\_

Approximate date: 

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**BMH03E1**

3f) Describe: **BMH03F** \_\_\_\_\_

Approximate date: 

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**BMH03F1**

3g) Describe: **BMH03G** \_\_\_\_\_

Approximate date: 

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**BMH03G1**

3h) Describe: **BMH03H** \_\_\_\_\_

Approximate date: 

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**BMH03H1**

3i) Describe: **BMH03I** \_\_\_\_\_

Approximate date: 

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**BMH03I1**

3j) Describe: **BMH03J** \_\_\_\_\_

Approximate date: 

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**BMH03J1**

4) Do you get an influenza vaccination (flu shot) every year? **BMH04**

Yes

I get a flu shot some years

I've never had a flu shot → **Go to 5**

4a) When was you most recent influenza vaccination? (month/year) ..... 

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**BMH04A**

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5) When was your most recent pneumonia vaccination? (Pneumovax) **BMH05**

- Never had
- Within past 5 years
- More than 5 years ago

6) Have you been diagnosed with alpha-1 anti-trypsin deficiency? **BMH06**

- Yes
- No
- Don't know

**Have you ever seen a physician or other medical provider for any of the following kinds of problems?**

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
7) Eyes, ears, nose, throat			
a) Vision problems <b>BMH07A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07A1</b> _____
b) Hearing problems <b>BMH07B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07B1</b> _____
c) Dizziness <b>BMH07C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07C1</b> _____
d) Ears ringing <b>BMH07D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07D1</b> _____
e) Sinusitis/rhinitis <b>BMH07E</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07E1</b> _____
f) Other <b>BMH07F</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH07F1</b> _____

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
8) Cardiovascular			
a) High blood pressure <b>BMH08A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08A1</b> _____
b) Coronary artery disease <b>BMH08B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08B1</b> _____
c) Angina (chest pain) <b>BMH08C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08C1</b> _____
d) Heart attack <b>BMH08D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08D1</b> _____
e) Murmur <b>BMH08E</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08E1</b> _____
f) Palpitations, irregular heartbeat <b>BMH08F</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08F1</b> _____
g) Valve disease <b>BMH08G</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08G1</b> _____
h) Congestive heart failure <b>BMH08H</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08H1</b> _____
i) Blood clots <b>BMH08I</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08I1</b> _____
j) Poor circulation (claudication) <b>BMH08J</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08J1</b> _____
k) Other <b>BMH08K</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH08K1</b> _____



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9) Gastrointestinal

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
a) Esophageal condition or disease	<input checked="" type="checkbox"/> BMH09A	<input type="checkbox"/>	BMH09A1 _____
b) Ulcers	<input type="checkbox"/> BMH09B	<input type="checkbox"/>	BMH09B1 _____
c) Hepatitis or jaundice	<input type="checkbox"/> BMH09C	<input type="checkbox"/>	BMH09C1 _____
d) Crohn's disease or colitis	<input type="checkbox"/> BMH09D	<input type="checkbox"/>	BMH09D1 _____
e) Gallstones	<input type="checkbox"/> BMH09E	<input type="checkbox"/>	BMH09E1 _____
f) Cirrhosis	<input type="checkbox"/> BMH09F	<input type="checkbox"/>	BMH09F1 _____
g) GERD (heart burn)	<input type="checkbox"/> BMH09G	<input type="checkbox"/>	BMH09G1 _____
h) Hiatal hernia	<input type="checkbox"/> BMH09H	<input type="checkbox"/>	BMH09H1 _____
i) Other	<input type="checkbox"/> BMH09I	<input type="checkbox"/>	BMH09I1 _____

10) Pulmonary/vascular

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
a) Intubation or respirator	<input checked="" type="checkbox"/> BMH10A	<input type="checkbox"/>	BMH10A1 _____
b) Pneumothorax (collapsed lung)	<input type="checkbox"/> BMH10B	<input type="checkbox"/>	BMH10B1 _____
c) Tuberculosis	<input type="checkbox"/> BMH10C	<input type="checkbox"/>	BMH10C1 _____
d) Pulmonary fibrosis	<input type="checkbox"/> BMH10D	<input type="checkbox"/>	BMH10D1 _____
e) Lung nodules	<input type="checkbox"/> BMH10E	<input type="checkbox"/>	BMH10E1 _____
f) Pulmonary embolism	<input type="checkbox"/> BMH10F	<input type="checkbox"/>	BMH10F1 _____
g) Other	<input type="checkbox"/> BMH10G	<input type="checkbox"/>	BMH10G1 _____

11) Oncology/hematology

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
a) Cancer (except basal cell skin cancer)	<input checked="" type="checkbox"/> BMH11A	<input type="checkbox"/>	BMH11A1 _____
b) Anemia	<input type="checkbox"/> BMH11B	<input type="checkbox"/>	BMH11BEXP _____
c) Other	<input type="checkbox"/> BMH11C	<input type="checkbox"/>	BMH11C1 _____

12) Genitourinary and reproductive

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
a) Menstrual symptoms (women)	<input checked="" type="checkbox"/> BMH12A	<input type="checkbox"/>	BMH12A1 _____
b) Enlarged prostate or BPH (men)	<input type="checkbox"/> BMH12B	<input type="checkbox"/>	BMH12B1 _____
c) Bladder or kidney problems/ kidney stones	<input type="checkbox"/> BMH12C	<input type="checkbox"/>	BMH12C1 _____
d) Other	<input type="checkbox"/> BMH12D	<input type="checkbox"/>	BMH12DEXP _____

13) Endocrine

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
a) Diabetes	<input type="checkbox"/> BMH13A	<input type="checkbox"/>	BMH13A1 _____
b) Thyroid	<input type="checkbox"/> BMH13B	<input type="checkbox"/>	BMH13B1 _____
c) Other	<input type="checkbox"/> BMH13C	<input type="checkbox"/>	BMH13CEXP _____

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14) Neurology

	Yes	No	Explain
a) Stroke <b>BMH14A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14A1</b> _____
b) Headaches <b>BMH14B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14B1</b> _____
c) Seizure <b>BMH14C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14C1</b> _____
d) Other <b>BMH14D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH14D1</b> _____

15) Muscular/skeletal

	Yes	No	Explain
a) Rheumatoid arthritis <b>BMH15A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15A1</b> _____
b) Gout <b>BMH15B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15B1</b> _____
	Yes	No	Explain .....
c) Osteoporosis <b>BMH15C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15C1</b> _____
d) Fractures <b>BMH15D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15D1</b> _____
e) Joint pain <b>BMH15E</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15E1</b> _____
f) Osteoarthritis <b>BMH15F</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15F1</b> _____
g) Other <b>BMH15G</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH15G1</b> _____

16) Dermatology

	Yes	No	Explain
a) Rashes/hives/eczema <b>BMH16A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16A1</b> _____
b) Psoriasis <b>BMH16B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16BEXP</b> _____
c) Shingles <b>BMH16C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16C1</b> _____
d) Other <b>BMH16D</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH16D1</b> _____

17) Infectious disease

	Yes	No	Explain
a) Atypical mycobacteria (MAC, MAI) <b>BMH17A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH17A1</b> _____
b) Fungal disease <b>BMH17B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH17B1</b> _____
c) Other <b>BMH17C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH17C1</b> _____

18) Psychiatric

	Yes	No	Explain
a) Anxiety <b>BMH18A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH18A1</b> _____
b) Depression <b>BMH18B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH18B1</b> _____
c) Other <b>BMH18C</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BMH18C1</b> _____

19) Other significant problems not reported in questions 2-18 **BMH19**

	Yes	No	
a) <b>BMH19A</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) <b>BMH19B</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) <b>BMH19C</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) <b>BMH19D</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
e) <b>BMH19E</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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**These next questions refer to recent illnesses or problems you may have had.**

20) In the last two weeks have you had any of the following:

20a) A fever, cold, flu, or sore throat? (Y/N) .....  **BMH20A**

20b) A urinary tract infection? (Y/N) .....  **BMH20B**

20c) Seasonal allergies? (Y/N) .....  **BMH20C**

20d) A sinus infection or sinusitis? (Y/N) .....  **BMH20D**

20e) A tooth infection? (Y/N) .....  **BMH20E**

20f) A flare up of gout? (Y/N) .....  **BMH20F**

20g) A flare up of arthritis? (Y/N) .....  **BMH20G**

20h) Other? (Y/N) .....  **BMH20H**

20i) Please explain: **BMH20I** \_\_\_\_\_

21) Are you allergic to any medications, latex, food, or substances? (Y/N) .....  **BMH21**

If **YES**:

List substance:	Reaction
a) <b>BMH21A</b>	<b>BMH21A1</b>
b) <b>BMH21B</b>	<b>BMH21B1</b>
c) <b>BMH21C</b>	<b>BMH21C1</b>
d) <b>BMH21D</b>	<b>BMH21D1</b>
e) <b>BMH21E</b>	<b>BMH21E1</b>

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22) In the past 12 months, how often have you consumed any alcohol containing beverage (beer, wine, wine coolers, liquor, or mixed drinks such as margaritas, martinis, or daiquiris)? (check only one) **BMH22**

- Every Day .....
- 4 to 6 days per week .....
- 2 to 3 days per week .....
- Once per week .....
- 1 to 3 times per month .....
- Less than once per month .....
- No alcohol in the past 12 months .....  → **Go to 29**

23) When you drink alcohol containing beverages, how many do you usually drink at one sitting? (check only one) **BMH23**

- 1 or 2 .....
- 3 or 4 .....
- 5 or 6 .....
- More than 6 .....

24) What kind of alcoholic beverages do you usually drink? (check all that apply)

- Beer .....  **BMH24\_1**
- Wine .....  **BMH24\_2**
- Drinks containing liquor .....  **BMH24\_3**

25) How often do you have eight or more drinks on one occasion? **BMH25**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....

26) How often during the last year have you been unable to remember what happened the night before because you had been drinking? **BMH26**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....



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36) Have you ever been pregnant (*include miscarriage, abortions*)? .....  **BMH36**  
Yes ..... Y  
No ..... N → **Go to 40**

37) If you have been pregnant, how old were you at the time of your first pregnancy? .....   **BMH37** yrs old

38) How many times have you been pregnant? .....   **BMH38**

39) Did you ever breastfeed? .....  **BMH39**  
Yes ..... Y  
No ..... N → **Go to 40**

40) If you did breastfeed, for approximately how many total months did you breastfeed  
(*total for all pregnancies*)? .....   **BMH40** months

41) Have you ever had an ovary removed? .....  **BMH41**  
Yes ..... Y  
No ..... N → **Go to 43**

42) If you had an ovary removed, was one removed or both? .....  **BMH42**  
One ..... O  
Both ..... B

43) At what age was your ovary or ovaries removed? .....   **BMH43** yrs old



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- 7) Time third blood pressure taken: ..... **BPF07**: 

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 AM / PM (*circle one*) **BPF07\_AMPM**
- a) Systolic ..... 

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 mm Hg **BPF07A**
- b) Diastolic ..... 

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 mm Hg **BPF07B**
- c) Heart Rate ..... 

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 beats/min **BPF07C**





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### **SALINE SPECIMENS**

7. Time Sterile Saline placed in freezer:       AM / PM (Circle One)

8. Time Scope Saline placed in freezer:       AM / PM (Circle One)

### **PROTECTED BRUSH SPECIMEN**

9. Time Processed:     AM / PM (Circle One)

10. Problems Processing?  Yes  No

Blood in the sample

Other

Specify:

11. Time placed in refrigerator:     AM / PM (Circle One)

12. Date moved to freezer:   /   /

13. Time placed in freezer:     AM / PM (Circle One)

### **INITIAL AIRWAY WASH**

14. Was more than 8mL returned from the first 20 cc airway wash? (Y/N)    
If No, skip to question 19 (Cell Count)

Microbiome sample in RNALater:

15. Time Processed:     AM / PM (Circle One)

16. Time placed in refrigerator:     AM / PM (Circle One)

17. Date moved to freezer:   /   /

18. Time placed in freezer:     AM / PM (Circle One)

Cell count:

19. Time Processed:     AM / PM (Circle One)

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20. Total volume returned: .  mL **BPW18**

21. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup> =  **BPW19** cells/mL

22. Total cell count= # cells/mL x Wash returned =  cells **BPW20**

23. Cytospin suspension= Total cells in 10 mL tube= # cells/mL x volume of wash in 10mL tube=  
 cells in 10 mL tube **BPW21**

24. Volume to resuspend pellet in with PBS= # cells in tube/0.7 x 10<sup>6</sup> = .  mL **BPW22**

25. Number of cytospin slides created:  **BPW23**

Supernatant Aliquots

26. Time Processed:  **BPW24**  AM / PM (Circle One) **BPW24A**

27. Number of 500ul aliquots created:  **BPW25**

28. Time placed in freezer.....  **BPW26**  AM / PM (Circle One) **BPW26A**

QIAzol RNA prep of cell pellet

29. Time Processed:  **BPW27**  AM / PM (Circle One) **BPW27A**

30. Time placed in freezer.....  **BPW28**  AM / PM (Circle One) **BPW28A**

**BAL:**

31. Time Processed:  **BPW29**  AM / PM (Circle One) **BPW29A**

32. Total volume returned: .  mL **BPW30**

33. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup>:  **BPW31** cells/mL

34. Total cell count= # cells/mL x BAL returned:  cells **BPW32**

35. Cytospin suspension= Total cells in 10 mL tube= # cells/mL x 10 mL:  **BPW33** cells in 10 mL tube

36. Volume to resuspend pellet in with PBS= # cells in tube/0.7 x 10<sup>6</sup>: .  mL **BPW34**

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Microbiome sample with RNA Later:

37a. Time Processed:  AM / PM (Circle One)

37b. Time placed in refrigerator ....  AM / PM (Circle One)

38a. Date moved to freezer: .....  /  /

38b. Time placed in freezer .....  AM / PM (Circle One)

Microbiome sample with no reagent:

39. Time transferred to 15mL conical:  AM / PM (Circle One)

40. Time placed in freezer:  AM / PM (Circle One)

Supernatant sample:

41. Time Processed:  AM / PM (Circle One)

42. Number of 500ul aliquots made:

42a. Number of 15mL aliquots made:

43. Time placed in freezer .....  AM / PM (Circle One)

Cytospin slide sample:

44. Time Processed:  AM / PM (Circle One)

45. Number of cytospin slides:

46. Time stained:  AM / PM (Circle One)

Alveolar Macrophage Isolation

47. Time Processed:  AM / PM (Circle One)  (must be exactly 2 hours after collection)

47b. Volume of BAL remaining: .  mL   
(This is the volume after microbiome (if done), cell count, and cytospin samples are completed)

The total cell concentration remaining (volume of BAL remaining \* Question 34 above)/10mL:

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48a. Is the time processed less than 2 hours after collection? (Y/N)  BPW46 BPW46A

b. Minutes since collection:  BPW46B

c. Reason processed before 2 hours:  BPW46C

49a. Is the time processed more than 2 hours after collection? (Y/N)  BPW47A

b. Minutes since collection:  BPW47B

c. Reason processed after 2 hours:  BPW47C

50. Time Processing Complete:  AM / PM (Circle One) BPW48A

51. Time Placed in freezer:  AM / PM (Circle One) BPW49A

Immunophenotyping BAL:

52. Time Processed:  AM / PM (Circle One) BPW50A

53. Number of pre-made BAL assay antibody tubes used:  BPW51

54. Time placed in refrigerator:  AM / PM (Circle One) BPW52A

**EPITHELIAL BRUSHES:**

55. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No BPW53

Blood in the sample BPW53A

Other BPW53B

Specify:  BPW53C

Cytospin Slides:

56. Time Processed:  AM / PM (Circle One) BPW54A

57. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup>:  cells/mL BPW55

58. Number of cytopsin slides:  BPW56

Epithelial RNA Extraction:

59. Time Processed:  AM / PM (Circle One) BPW57A

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60. Time placed in freezer:  AM / PM (Circle One)

**SMALL AIRWAYS EPITHELIAL BRUSHES (OPTIONAL):**

61. Were small airways epithelial brushings collected?  Yes  No

62. Problems Processing?  Yes  No

Blood in the sample

Other

Specify:

Cytospin Slides:

63. Time Processed:  AM / PM (Circle One)

64. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup>:  cells/mL

65. Number of cytospin slides:

Epithelial RNA Extraction:

66. Time Processed:  AM / PM (Circle One)

67. Time placed in freezer:  AM / PM (Circle One)

**BIOPSIES:**

Snap Frozen Biopsies:

68. Time placed in freezer:  AM / PM (Circle One)

Formalin Fixed Biopsies:

69. Time placed in cold 10% formalin:  AM / PM (Circle One)

70. Time moved to fresh cold 10% formalin:  AM / PM (Circle One)

71. Time placed in 70% alcohol at 4 degrees (after formalin fixation):  AM / PM (Circle One)

72. Date biopsies placed in 70% alcohol (after formalin fixation): //

ID NUMBER:									
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SEQ #			
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73. Number of biopsies moved to 70% alcohol:  **BPW73**

74. If biopsies were lost between collection and the final step of sample fixation, please describe how and why they were lost: **BPW74**

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75. Was subsequent biopsy processing and paraffin embedding completed by a core lab (Y/N)?  **BPW75**

76. Date biopsies sent to pathology lab: // **BPW76**

77. Date paraffin block(s) returned from pathology lab: // **BPW77**

78. Number of paraffin block(s):  **BPW78**



# BRONCHOSCOPY SPECIMEN PROCESSING WORKSHEET

ID NUMBER:	<b>BLINDID</b>	FORM CODE: <b>BPW</b>	Visit	<b>VISIT</b>	SEQ #			
		VERSION: 2.0 3/01/12	Number					

0a. Form Completion Date.....   /   /     **BPW0A** 0b. Initials.....     **BPW0B**

**Instructions:** This form should be completed during the participant's visit. 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.

## BLOOD

### 1. Heparin Tube for Immunophenotyping

- a. Time Processed:   :   AM / PM (Circle One) **BPW1A** **BPW1A1**  
h h : m m
- b. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No **BPW1B**
- Broken Tube **BPW1B1**
  - Clotted **BPW1B3**
  - Hemolyzed **BPW1B4**
  - Lipemic **BPW1B5**
  - Other **BPW1B6**
- Specify:  **BPW1B7**
- c. Number of pre-made blood assay antibody tubes used:  **BPW1C**
- d. Time aliquots placed in refrigerator   :   AM / PM (Circle One) **BPW1D** **BPW1D1**

## ORAL SPECIMEN

2. Time Processed:   :   AM / PM (Circle One) **BPW2** **BPW2A**
3. Number of 15mL conical tubes:  **BPW3**
4. Time 15mL conical tubes placed in refrigerator:   :   AM / PM (Circle One) **BPW4** **BPW4A**
5. Date 15mL conical tubes moved to freezer:   /   /      **BPW5**
6. Time 15mL conical tubes placed in freezer:   :   AM / PM (Circle One) **BPW6**



ID NUMBER:

FORM CODE: BPW  
VERSION: 2.0 03/01/12

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**PROTECTED BRUSH SPECIMEN**

7. Time Processed:  :  AM / PM (Circle One)

8. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No

Blood in the sample

Other

Specify:

9. Time placed in refrigerator:  :  AM / PM (Circle One)

10. Date moved to freezer:  /  /

11. Time placed in freezer:  :  AM / PM (Circle One)

**INITIAL AIRWAY WASH**

12. Was more than 8mL returned from the first 20 cc airway wash? (Y/N)    
If No, skip to question 17 (Cell Count)

Microbiome sample:

13. Time Processed:  :  AM / PM (Circle One)

14. Time placed in refrigerator:  :  AM / PM (Circle One)

15. Date moved to freezer:  /  /

16. Time placed in freezer:  :  AM / PM (Circle One)

Cell count:

17. Time Processed:  :  AM / PM (Circle One)

18. Total volume returned:  .  mL

19. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup> =  cells/mL

ID NUMBER:

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SEQ #

20. Total cell count= # cells/mL x Wash returned =  cells **BPW20**

21. Cytospin suspension= Total cells in 10 mL tube= # cells/mL x volume of wash in 10mL tube=  
 cells in 10 mL tube **BPW21**

22. Volume to resuspend pellet in with PBS= # cells in tube/0.7 x 10<sup>6</sup> = .  mL **BPW22**

23. Number of cytopsin slides created:  **BPW23**

Supernatant Aliquots

24. Time Processed: .  AM / PM (Circle One) **BPW24** **BPW24A**

25. Number of 500ul aliquots created:  **BPW25**

26. Time placed in freezer..... .  AM / PM (Circle One) **BPW26** **BPW26A**

QIAzol RNA prep of cell pellet

27. Time Processed: .  AM / PM (Circle One) **BPW27** **BPW27A**

28. Time placed in freezer..... .  AM / PM (Circle One) **BPW28** **BPW28A**

**BAL:**

29. Time Processed: .  AM / PM (Circle One) **BPW29** **BPW29A**

30. Total volume returned: .  mL **BPW30**

31. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup>:  cells/mL **BPW31**

32. Total cell count= # cells/mL x BAL returned:  cells **BPW32**

33. Cytospin suspension= Total cells in 10 mL tube= # cells/mL x 10 mL:  cells in 10 mL tube **BPW33**

34. Volume to resuspend pellet in with PBS= # cells in tube/0.7 x 10<sup>6</sup>: .  mL **BPW34**

ID NUMBER:

FORM CODE: BPW  
VERSION: 2.0 03/01/12

Visit Number

SEQ #

Microbiome sample:

35. Time Processed:  AM / PM (Circle One)

36. Time placed in refrigerator .....  AM / PM (Circle One)

37. Date moved to freezer:.....  /  /

38. Time placed in freezer.....  AM / PM (Circle One)

Supernatant sample:

39. Time Processed:  AM / PM (Circle One)

40. Number of 500ul aliquots made:

40a. Number of 15mL aliquots made:

41. Time placed in freezer.....  AM / PM (Circle One)

Cytospin slide sample:

42. Time Processed:  AM / PM (Circle One)

43. Number of cytopsin slides:

44. Time stained:  AM / PM (Circle One)

Alveolar Macrophage Isolation

45. Time Processed:  AM / PM (Circle One) **(must be exactly 2 hours after collection)**

45b. Volume of BAL remaining:  .  mL   
(This is the volume after microbiome (if done), cell count, and cytopsin samples are completed)

Total cell concentration remaining (volume of BAL remaining \* Question 32 above)/10mL:

46a. Is the time processed less than 2 hours after collection? (Y/N)

b. Minutes since collection:

c. Reason processed before 2 hours: \_\_\_\_\_

ID NUMBER:

FORM CODE: BPW  
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Visit Number

SEQ #

47a. Is the time processed more than 2 hours after collection? (Y/N)  **BPW47A**

b. Minutes since collection:    **BPW47B**

c. Reason processed after 2 hours: \_\_\_\_\_ **BPW47C**

48. Time Processing Complete:     AM / PM (Circle One) **BPW48A**

49. Time Placed in freezer:     AM / PM (Circle One) **BPW49A**

Immunophenotyping BAL:

50. Time Processed:     AM / PM (Circle One) **BPW50A**

51. Number of pre-made BAL assay antibody tubes used:  **BPW51**

52. Time placed in refrigerator:     AM / PM (Circle One) **BPW52A**

**EPITHELIAL BRUSHES:**

53. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No **BPW53**

Blood in the sample **BPW53A**

Other **BPW53B**

Specify: \_\_\_\_\_ **BPW53C**

Cytospin Slides:

54. Time Processed:     AM / PM (Circle One) **BPW54A**

55. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup>:           cells/mL **BPW55**

56. Number of cytospin slides:  **BPW56**

Epithelial RNA Extraction:

57. Time Processed:     AM / PM (Circle One) **BPW57A**

58. Time placed in freezer:     AM / PM (Circle One) **BPW58A**

ID NUMBER:									
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FORM CODE: BPW  
VERSION: 2.0 03/01/12

Visit Number		
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SEQ #			
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**BIOPSIES:**

Snap Frozen Biopsies:

59. Time placed in freezer: BPW59

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 AM / PM (Circle One) BPW59A

Formalin Fixed Biopsies:

60. Time placed in cold 10% formalin: BPW60

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 AM / PM (Circle One) BPW60A

61. Time moved to fresh cold 10% formalin: BPW61

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 AM / PM (Circle One) BPW61A

62. Time placed in 70% alcohol at 4 degrees: BPW62

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 AM / PM (Circle One) BPW62A



ID NUMBER:

FORM CODE: BPW  
VERSION: 1.0 10/27/11

Visit Number

SEQ #

**PROTECTED BRUSH SPECIMEN**

7. Time Processed:  AM / PM (Circle One)

8. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No

Blood in the sample

Other

Specify:

9. Time placed in refrigerator: :  AM / PM (Circle One)

10. Date moved to freezer: //

11. Time placed in freezer:  AM / PM (Circle One)

**INITIAL AIRWAY WASH**

12. Was more than 8mL returned from the first 20 cc airway wash? (Y/N)

Microbiome sample:

13. Time Processed:  AM / PM (Circle One)

14. Time placed in refrigerator:  AM / PM (Circle One)

15. Date moved to freezer: //

16. Time placed in freezer:  AM / PM (Circle One)

Cell count:

17. Time Processed:  AM / PM (Circle One)

18. Total volume returned:  mL

19. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup> =  cells/mL

ID NUMBER:

FORM CODE: BPW  
VERSION: 1.0 10/27/11

Visit Number

SEQ #

20. Total cell count= # cells/mL x BAL returned =  **BPW20**  
cells

21. Cytospin suspension= Total cells in 10 mL tube= # cells/mL x 10 mL =  **BPW21**  
cells in 10 mL tube

22. Volume to resuspend pellet in with PBS= # cells in tube/0.7 x 10<sup>6</sup> =  mL **BPW22**

23. Number of cytospin slides created:  **BPW23**

Supernatant Aliquots

24. Time Processed:  :  AM / PM (Circle One) **BPW24** **BPW24A**

25. Number of aliquots created:  **BPW25**

26. Time placed in freezer.....  :  AM / PM (Circle One) **BPW26** **BPW26A**

QIAzol RNA prep of cell pellet

27. Time Processed:  :  AM / PM (Circle One) **BPW27** **BPW27A**

28. Time placed in freezer.....  :  AM / PM (Circle One) **BPW28** **BPW28A**

**BAL:**

29. Time Processed:  :  AM / PM (Circle One) **BPW29** **BPW29A**

30. Total volume returned:  mL **BPW30**

31. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup>:  cells/mL **BPW31**

32. Total cell count= # cells/mL x BAL returned:  cells **BPW32**

33. Cytospin suspension= Total cells in 10 mL tube= # cells/mL x 10 mL:  cells in **BPW33**  
10 mL tube

34. Volume to resuspend pellet in with PBS= # cells in tube/0.7 x 10<sup>6</sup>:  mL **BPW34**

Microbiome sample:



ID NUMBER:

FORM CODE: BPW  
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Visit  
Number

SEQ #

35. Time Processed:   AM / PM (Circle One)

36. Time placed in refrigerator .....   AM / PM (Circle One)

37. Date moved to freezer:..... //

38. Time placed in freezer.....   AM / PM (Circle One)

Supernatant sample:

39. Time Processed:   AM / PM (Circle One)

40. Number of aliquots made:

41. Time placed in freezer.....   AM / PM (Circle One)

Cytospin slide sample:

42. Time Processed:   AM / PM (Circle One)

43. Number of cytospin slides:

44. Time stained:   AM / PM (Circle One)

Alveolar Macrophage Isolation

45. Time Processed:   AM / PM (Circle One)  **(must be exactly 2 hours after collection)**

46a. Is the time processed less than 2 hours after collection? (Y/N)

b. Minutes since collection:

c. Reason processed before 2 hours: \_\_\_\_\_

47a. Is the time processed more than 2 hours after collection? (Y/N)

b. Minutes since collection:

c. Reason processed after 2 hours: \_\_\_\_\_

48. Time Processing Complete:   AM / PM (Circle One)

ID NUMBER:

FORM CODE: BPW  
VERSION: 1.0 10/27/11

Visit Number

SEQ #

49. Time Placed in freezer:     AM / PM (Circle One)

Immunophenotyping BAL:

50. Time Processed:     AM / PM (Circle One)

51. Number of pre-made BAL assay antibody tubes used:

52. Time placed in refrigerator:     AM / PM (Circle One)

**EPITHELIAL BRUSHES:**

53. Problems Processing? <sup>1</sup>Yes <sup>0</sup>No

Blood in the sample

Other

Specify:

Cytospin Slides:

54. Time Processed:     AM / PM (Circle One)

55. Cell count= # cells/mL= (# cells in 4 squares/4) x 2 x 10<sup>4</sup>:         cells/mL

56. Number of cytospin slides:

Epithelial RNA Extraction:

57. Time Processed:     AM / PM (Circle One)

58. Time placed in refrigerator:     AM / PM (Circle One)

**BIOPSIES:**

Snap Frozen Biopsies:

59. Time placed in freezer:     AM / PM (Circle One)

Formalin Fixed Biopsies:

ID NUMBER:									
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FORM CODE: BPW  
VERSION: 1.0 10/27/11

Visit Number		
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SEQ #			
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60. Time placed in cold 10% formalin: BPW60

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 AM / PM (Circle One) BPW60A

61. Time moved to fresh cold 10% formalin: BPW61

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 AM / PM (Circle One) BPW61A

62. Time placed in 70% alcohol at 4 degrees: BPW62

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 AM / PM (Circle One) BPW62A



# BERLIN SLEEP QUESTIONNAIRE

ID NUMBER:	<b>BLINDID</b>				
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FORM CODE: BSQ  
VERSION: 1.0 10/26/10

Visit Number	<b>VISIT</b>
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SEQ #			
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0a) Form Date .....   /   /     **BSQ0A**      0b) Initials .....

**Instructions:** This form should be completed during the participant's visit. Please read questions exactly as written, and read all responses to the participant before recording an answer.

**This questionnaire assess breathing trouble while sleeping. I will read you all the response choices. Please select the best response for you for each question.**

### Category 1

1) Do you snore? .....  **BSQ01**  
     Yes..... Y  
     No ..... N → **Go to 5**  
     Don't know ..... U → **Go to 5**

*If you snore:*

2) Your snoring is: .....  **BSQ02**  
     Slightly louder than breathing ..... A  
     As loud as talking ..... B  
     Louder than talking ..... C  
     Very loud—can be heard in adjacent rooms ..... D

3) How often do you snore? .....  **BSQ03**  
     Nearly every day ..... A  
     3-4 times a week ..... B  
     1-2 times a week ..... C  
     1-2 times a month ..... D  
     Never or nearly never ..... E

4) Has your snoring ever bothered other people? .....  **BSQ04**  
     Yes..... Y  
     No ..... N  
     Don't know ..... U

ID NUMBER:								
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FORM CODE: BSQ  
VERSION: 1.0 10/26/10

Visit  
Number 

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SEQ # 

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- 5) Has anyone noticed that you quit breathing during your sleep? .....  **BSQ05**
- Nearly every day .....A
  - 3-4 times a week .....B
  - 1-2 times a week .....C
  - 1-2 times a month .....D
  - Never or nearly never .....E

**Category 2**

- 6) How often do you feel tired or fatigued after your sleep? .....  **BSQ06**
- Nearly every day .....A
  - 3-4 times a week .....B
  - 1-2 times a week .....C
  - 1-2 times a month .....D
  - Never or nearly never .....E

- 7) During your waking time, do you feel tired, fatigued or not up to par? .....  **BSQ07**
- Nearly every day .....A
  - 3-4 times a week .....B
  - 1-2 times a week .....C
  - 1-2 times a month .....D
  - Never or nearly never .....E

- 8) Have you ever nodded off or fallen asleep while driving a vehicle? .....  **BSQ08**
- Yes ..... Y
  - No ..... N → **Go to 10**

*If yes:*

- 9) How often does this occur? .....  **BSQ09**
- Nearly every day .....A
  - 3-4 times a week .....B
  - 1-2 times a week .....C
  - 1-2 times a month .....D
  - Never or nearly never .....E

**Category 3**

- 10) Do you have high blood pressure? .....  **BSQ10**
- Yes ..... Y
  - No ..... N
  - Don't know ..... U



ID NUMBER:

FORM CODE: BSW  
VERSION: 2.0 03/06/12

Visit Number

SEQ #

3. General Notes/Comments: **BSW4**

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4. Time immunophenotyping processing began: ..... **BSW5** :   **BSW5A** AM/PM (circle 1)

5. Weight of the 50mL Centrifuge tube: .....    .   grams **BSW6**

*Remember to zero the balance.*

6. Weight of the sputum: .....    .   grams **BSW7**

*Make up 1x Sputolysin: combine 1 ml of sputolysin with 9 mls of distilled water and swirl gently to dissolve crystals*

7. Volume of Sputolysin to add (weight of sputum x2): .....    .   mL **BSW8**

8. Time placed in 37°C water bath: ..... **BSW10** :   **BSW10A** AM/PM (circle 1)

*Leave in bath approximately 20 minutes or until the sputum appears viscous with vortexing every 5 minutes.*

9. Number of times vortexed: .....   **BSW11**

10. Time removed from water bath: ..... **BSW12** :   **BSW12A** AM/PM (circle 1)

11. Volume of PBS added: .....    .   mL **BSW13**

*Centrifuge at 300 x g for 5 mins, then decant supernatant. Resuspend cells in 1.0 ml Stain Buffer. Briefly centrifuge immunophenotyping sputum assay antibody tubes (supplied by immunophenotyping core) at 300 x g for 2 mins and uncap tubes*

12. Time pre-made sputum assay antibody tubes placed in centrifuge: ..... **BSW14** :   **BSW14A** AM/PM (circle 1)

*Add 100 µl of sputum sample to each tube. Wrap rack with tinfoil to protect from light.*

13. Number of pre-made sputum assay antibody tubes used: .....   **BSW15**

ID NUMBER:									
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FORM CODE: BSW  
VERSION: 2.0 03/06/12

Visit Number		
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SEQ #			
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*Incubate tubes for 25 minutes at room temperature, with shaking or rocking.*

14. Time incubation begin: ..... **BSW16** :   **BSW16A** AM/PM (circle 1)

15. Time incubation end: ..... **BSW17** :   **BSW17A** AM/PM (circle 1)

*Add 2 mls of Stain Buffer to each tube. Centrifuge at 300 x g for 5 mins. Decant supernatant. Prepare 2% formaldehyde solution: Combine 0.2 mls 20% formaldehyde with 1.8 mls Stain Buffer. Add 200 µl of 2% formaldehyde to each tube. Replace caps on tubes; they should snap firmly into place. Wrap rack in a new sheet of tinfoil. Store at 4°C until ready to be shipped*

16. Time placed in 4°C storage: ..... **BSW18** :   **BSW18A** AM/PM (circle 1)

17. Problems processing: **BSW19**

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ID NUMBER:

FORM CODE: BSW  
VERSION: 1.0 10/27/11

Visit Number

SEQ #

4. General Notes/Comments: **BSW4**

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5. Time processing began: ..... **BSW5** :   **BSW5A** AM/PM (circle 1)

6. Weight of the 50mL Centrifuge tube: .....    .   grams **BSW6**

*Remember to zero the balance.*

7. Weight of the sputum: .....    .   grams **BSW7**

*Make up 1x Sputolysin: combine 1 ml of sputolysin with 9 mls of distilled water and swirl gently to dissolve crystals*

8. Volume of Sputolysin to add (weight of sputum x2): .....    .   mL **BSW8**

9. Total volume of sputum plus sputolysin: .....    .   mL **BSW9**

10. Time placed in 37°C water bath: ..... **BSW10** :   **BSW10A** AM/PM (circle 1)

*Leave in bath approximately 20 minutes or until the sputum appears viscous with vortexing every 5 minutes.*

11. Number of times vortexed: .....   **BSW11**

12. Time removed from water bath: ..... **BSW12** :   **BSW12A** AM/PM (circle 1)

13. Volume of PBS added: .....    .   mL **BSW13**

*Centrifuge at 300 x g for 5 mins, then decant supernatant. Resuspend cells in 1.0 ml Stain Buffer. Briefly centrifuge immunophenotyping sputum assay antibody tubes (supplied by immunophenotyping core) at 300 x g for 2 mins and uncap tubes*

14. Time pre-made sputum assay antibody tubes placed in centrifuge: ..... **BSW14** :   **BSW14A** AM/PM (circle 1)

*Add 100 µl of sputum sample to each tube. Wrap rack with tinfoil to protect from light.*

15. Number of pre-made sputum assay antibody tubes used: .....   **BSW15**

ID NUMBER:									
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FORM CODE: BSW  
VERSION: 1.0 10/27/11

Visit Number		
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SEQ #			
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*Incubate tubes for 25 minutes at room temperature, with shaking or rocking.*

16. Time incubation begin: ..... **BSW16**:   **BSW16A** AM/PM (circle 1)

17. Time incubation end: ..... **BSW17**:   **BSW17A** AM/PM (circle 1)

*Add 2 mls of Stain Buffer to each tube. Centrifuge at 300 x g for 5 mins. Decant supernatant. Prepare 2% formaldehyde solution: Combine 0.2 mls 20% formaldehyde with 1.8 mls Stain Buffer. Add 200 µl of 2% formaldehyde to each tube. Replace caps on tubes; they should snap firmly into place. Wrap rack in a new sheet of tinfoil. Store at 4°C until ready to be shipped*

18. Time placed in 4°C storage: ..... **BSW18**:   **BSW18A** AM/PM (circle 1)

19. Problems processing: **BSW19**

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ID NUMBER:

FORM CODE: CAF  
VERSION: A 2/16/2015

Visit  
Number

SEQ #

9. Tumor behavior: *(Mark only one)* **CAF9**

- a.  Invasive; malignant; infiltrating; micro-invasive
- b.  In situ; intraepithelial; non-infiltrating; non-invasive; intraductal
- c.  Borderline malignancy; low malignant potential; uncertain if benign or malignant
- d.  Unknown

10. Diagnostic confirmation status: *(Mark only one. If more than one applies, mark the first applicable category)* **CAF10**

- a.  Positive histology (pathology)
- b.  Positive cytology, no positive histology
- c.  Positive histology (pathology), regional or distant metastatic site only
- d.  Positive microscopic confirmation, method not specified
- e.  Clinical diagnosis only
- f.  Unknown

11. Laterality: *(Mark only one)* **CAF11**

- a.  Not a paired site
- b.  Right origin of primary
- c.  Left origin of primary
- d.  One side involved, right or left origin unspecified
- e.  Bilateral involvement, lateral origin unknown; stated to be a single primary
- f.  Paired site but no information on laterality; midline tumor

12. Summary stage: *(Mark only one)* **CAF12**

- a.  In situ
- b.  Localized
- c.  Regional
- d.  Distant
- e.  Unknown

**C. LUNG CANCER** *(Complete 13-16 for Lung cancer only)*

13. Is lung cancer the primary diagnosed cancer: Yes  No  *(If No, skip to Q17)* **CAF13**

14. Site of the lung cancer *(Mark one only)* **CAF14**

- |                     |                          |                         |                          |  |                          |                              |                          |
|---------------------|--------------------------|-------------------------|--------------------------|--|--------------------------|------------------------------|--------------------------|
| Trachea             | <input type="checkbox"/> | Main bronchus           | <input type="checkbox"/> | Upper lobe bronchus                    | <input type="checkbox"/> | Middle lobe bronchus         | <input type="checkbox"/> |
| Lower lobe bronchus | <input type="checkbox"/> | Other parts of bronchus | <input type="checkbox"/> | Overlapping lesion of bronchus or lung | <input type="checkbox"/> | Bronchus or lung unspecified | <input type="checkbox"/> |
| Parietal pleura     | <input type="checkbox"/> | Visceral pleura         | <input type="checkbox"/> | Other site, pleura                     | <input type="checkbox"/> | Pleura, unspecified          | <input type="checkbox"/> |

ID NUMBER:									
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FORM CODE: CAF  
VERSION: A 2/16/2015

Visit  
Number

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SEQ #

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15. Type of lung cancer (*Mark only one*) **CAF15**

- a.  Non-small cell lung cancer
  - 1.  Adenocarcinoma
  - 2.  Squamous / epitheloid carcinoma
  - 3.  Large cell carcinoma
  - 4.  Unspecified
- b.  Small cell lung cancer
- c.  Type unknown
- d. Other, specify \_\_\_\_\_ **CAF15A**

16. Treatments (*Mark all that apply*)

- a.  Surgery **CAF16A**
- b.  Chemotherapy **CAF16B**
  - 1.  Neoadjuvant **CAF16B1**
  - 2.  Adjuvant **CAF16B2**
- c.  Radiation **CAF16C**
- d.  Targeted drug treatment **CAF16D**
  - 1.  Bevacizumab (Avastin) **CAF16D1**
  - 2.  Crizotinib (Xalkori) **CAF16D2**
  - 3.  Erlotinib (Tarceva) **CAF16D3**

17. Smoking status (*Mark only one*)

- a. Former smoker **CAF17A1**
  - 1. Pack years: 10 or less  10 to 20  20 or more  Unknown
- b. Current smoker: Yes  No  Unknown  **CAF17B**

18. Did patient receive a lung transplant? Yes  No  Unknown  **CAF18**

- a.  Single Right **CAF18A**
- b.  Single Left
- c.  Bilateral



# COPD ASSESSMENT TEST

ID NUMBER:	<b>BLINDID</b>				
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FORM CODE: CAT  
VERSION: 1.0 10/26/10

Visit Number	<b>VISIT</b>
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SEQ #			
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0a) Form Date ..... // **CAT0A**      0b) Initials.....

**Instructions:** This form should be completed during the participant's visit. For each item below, have the participant select the number that best describes their experience.

**This questionnaire will help us measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on your wellbeing and daily life. For each item below, tell me the number that best describes you currently. Be sure to only select one response for each question**

									<b>SCORE</b>
1)	I never cough	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	I cough all the time	<b>CAT01</b> <input type="checkbox"/>
2)	I have no phlegm (mucus) in my chest at all	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	My chest is completely full of phlegm (mucus)	<b>CAT02</b> <input type="checkbox"/>
3)	My chest does not feel tight at all	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	My chest feels very tight	<b>CAT03</b> <input type="checkbox"/>
4)	When I walk up a hill or one flight of stairs I am not breathless	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	When I walk up a hill or one flight of stairs I am very breathless	<b>CAT04</b> <input type="checkbox"/>
5)	I am not limited doing any activities at home	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	I am very limited doing activities at home	<b>CAT05</b> <input type="checkbox"/>
6)	I am confident leaving my home despite my lung condition	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	I am not at all confident leaving my home because of my lung condition	<b>CAT06</b> <input type="checkbox"/>
7)	I sleep soundly	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	I don't sleep soundly because of my lung condition	<b>CAT07</b> <input type="checkbox"/>
8)	I have lots of energy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	I have no energy at all	<b>CAT08</b> <input type="checkbox"/>



# CBC RESULTS FORM

ID NUMBER:	<b>BLINDID</b>				
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FORM CODE: CBC  
VERSION: 1.1 2/16/11

Visit Number	<b>VISIT</b>
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SEQ #			
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0a. Form Completion Date: / /  **CBC0A** 0b. Initials:

**Instructions:** Input the results of your local lab into this form.

1. Date Blood Submitted to Lab: / /  **CBC01**

2. Date Results Received: / /  **CBC02**

### RED BLOOD CELLS

3. Total Red Blood Cells ..... .  x10<sup>12</sup>/L **CBC03**

4. Hemoglobin.....  .  g/dL **CBC04**

5. Hemacrit .....  .  % **CBC05**

6. Mean corpuscular volume .....   .  fL **CBC06**

7. Red blood cell distribution width .....  .  % **CBC07**

### WHITE BLOOD CELLS (ABSOLUTE VALUES)

8. Total white blood cells.....  .  x10<sup>9</sup>/L **CBC08**

9. Neutrophil granulocyte .....  .  x10<sup>9</sup>/L **CBC09**

9a. Neutrophil granulocyte %.....  .  % **CBC09A**

10. Lymphocytes.....  .  x10<sup>9</sup>/L **CBC10**

10a. Lymphocyte % .....  .  % **CBC10A**

11. Monocytes .....  .  x10<sup>9</sup>/L **CBC11**

11a. Monocyte % .....  .  % **CBC11A**



ID NUMBER:							
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FORM CODE: **LAB**  
VERSION: 1.0 10/26/10

Visit  
Number 

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SEQ # 

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12. Eosinophil granulocytes ..... 

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 x10<sup>9</sup>/L CBC12

12a. Eosinophil granulocyte % ..... 

--	--	--

 % CBC12A

13. Basophil granulocytes ..... 

--	--	--

 x10<sup>9</sup>/L CBC13

13a. Basophil granulocyte % ..... 

--	--	--

 % CBC13A

**PLATELETS**

14. Platelet Count ..... 

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 x10<sup>9</sup>/L CBC14

15. Mean Platelet Volume ..... 

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 fL CBC15

16. Comments: CBC16 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



ID NUMBER:							
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FORM CODE: **LAB**  
VERSION: 1.0 10/26/10

Visit  
Number 

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SEQ # 

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**PLATELETS**

14. Platelet Count ..... 

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 x10<sup>9</sup>/L **CBC14**

15. Mean Platelet Volume ..... 

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 fL **CBC15**

16. Comments: **CBC16**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



ID NUMBER:									
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FORM CODE: **CEA**  
 VERSION: **1.0** 05/27/14

Visit Number			SEQ #		
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3) Since the start or worsening of your symptoms, have you experienced any of the following for at least 2 or more consecutive days?

- |  | <u>Yes</u>               | <u>No</u>                |       |
|--|--------------------------|--------------------------|-------|
| a. Runny Nose/Nasal discharge .....      | <input type="checkbox"/> | <input type="checkbox"/> | CEA3a |
| b. Increase or worsening of wheeze ..... | <input type="checkbox"/> | <input type="checkbox"/> | CEA3b |
| c. Sore throat .....                     | <input type="checkbox"/> | <input type="checkbox"/> | CEA3c |
| d. Increase or worsening of cough .....  | <input type="checkbox"/> | <input type="checkbox"/> | CEA3d |
| e. Fever .....                           | <input type="checkbox"/> | <input type="checkbox"/> | CEA3e |

**HCU Event Determination**

4. Have you contacted your primary physician or gone to the emergency room, urgent care, or hospital regarding this change in your symptoms? .....  CEA4

Yes..... 1  
 No ..... 0 → Skip to 4d

4a. Date of contact with physician or emergency room/urgent care visit: // CEA4a

4b. Why did you contact your primary physician or go to the emergency room, urgent care, or hospital for this change in symptoms?

- |   | <u>Yes</u>               | <u>No</u>                |        |
|---|--------------------------|--------------------------|--------|
| 1. Sputum color change: the doctor told me to call if my sputum changes color | <input type="checkbox"/> | <input type="checkbox"/> | CEA4b1 |
| 2. Thought I might need extra treatment                                       | <input type="checkbox"/> | <input type="checkbox"/> | CEA4b2 |
| 3. Knew I needed treatment  | <input type="checkbox"/> | <input type="checkbox"/> | CEA4b3 |
| 4. Scared or nervous  | <input type="checkbox"/> | <input type="checkbox"/> | CEA4b4 |
| 5. Wanted to catch it early   | <input type="checkbox"/> | <input type="checkbox"/> | CEA4b5 |
| 6. Someone (spouse/child) told me to call                                     | <input type="checkbox"/> | <input type="checkbox"/> | CEA4b6 |
| 7. Other  | <input type="checkbox"/> | <input type="checkbox"/> | CEA4b7 |

7a. Specify: CEA4b7a \_\_\_\_\_

4c. Did the participant report going to the emergency room or hospital? ....  CEA4c

Yes ..... 1  
 No..... 0

ID NUMBER:									
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FORM CODE: **CEA**  
 VERSION: **1.0** 05/27/14

Visit Number		
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SEQ #		
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4d. Why didn't you contact your primary physician or go to the emergency room, urgent care, or hospital regarding this change in symptoms?

- |   | Yes                      | No                                      |
|---|--------------------------|---|
| 1. Inconvenient   | <input type="checkbox"/> | <input type="checkbox"/> <b>CEA4d1</b>  |
| a. Too far  | <input type="checkbox"/> | <input type="checkbox"/> <b>CEA4d1a</b> |
| b. Office not open                                      | <input type="checkbox"/> | <input type="checkbox"/> <b>CEA4d1b</b> |
| c. Could not make an appointment                        | <input type="checkbox"/> | <input type="checkbox"/> <b>CEA4d1c</b> |
| d. Other  | <input type="checkbox"/> | <input type="checkbox"/> <b>CEA4d1d</b> |
| e) Specify <b>CEA4d1e</b> _____                         | <input type="checkbox"/> | <input type="checkbox"/> <b>CEA4d1d</b> |
| 2. Cost (co-pay, medications, deductible)               | <input type="checkbox"/> | <input type="checkbox"/>                |
| 3. I have treatment at home to take when I feel worse   | <input type="checkbox"/> | <input type="checkbox"/>                |
| 4. I didn't feel sick enough to call.                   | <input type="checkbox"/> | <input type="checkbox"/>                |
| 5. I thought it would go away soon.                     | <input type="checkbox"/> | <input type="checkbox"/>                |
| 6. I knew it wasn't a problem (past experience)         | <input type="checkbox"/> | <input type="checkbox"/>                |
| 7. I don't like to bother my doctor                     | <input type="checkbox"/> | <input type="checkbox"/>                |
| 8. I don't like or prefer not to take extra medications | <input type="checkbox"/> | <input type="checkbox"/>                |
| 9. Other  | <input type="checkbox"/> | <input type="checkbox"/>                |
| 9a. Specify: _____                                      |                          |   |

CEA items 2-9 not used

5. (If yes to Q4) As a result of contacting your physician or going to the emergency room, urgent care, or hospital was there a change in your medical treatment (e.g., changed your medications)?  **CEA5**

Yes..... 1  
 No ..... 0 → Skip to 7

5a. Date of change in medical treatment: / /  **CEA5a**

6. (If no to Q4) Have you changed your medical treatment as directed by your physician because of the change in your symptoms (e.g., filled a prescription of antibiotics)?  **CEA6**

Yes..... 1  
 No ..... 0

6a. Date of change in medical treatment: / /  **CEA6a**

**Previous Event/Visit Determination (Do not read to participant)**

7. Has the participant had a previous HCU-triggered exacerbation AND completed a study visit for that exacerbation?  **CEA7**

Yes..... 1  
 No ..... 0 → Skip to 9

ID NUMBER:								
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FORM CODE: **CEA**  
 VERSION: **1.0** 05/27/14

Visit Number		
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SEQ #		
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8. Has the participant had at least three previous events AND completed study visits for these events?  **CEA8**  
 Yes..... 1 →END (Participant ineligible for another visit)  
 No ..... 0

**Visit Eligibility Determination (Do not read to participant)**

9. Is this participant eligible for an exacerbation clinic visit?  **CEA9**  
 Yes..... 1  
 No ..... 0 → End

*Eligibility Criteria:*

1) No history of previous HCU exacerbation visit (Q7 = N) and Q4 or Q6 = Y (HCU Exacerbation Visit)

10. Was the participant scheduled for a study visit?  **CEA10**  
 Yes..... 1 → End  
 No ..... 0

11. Reason participant was not scheduled for an exacerbation visit:

	<u>Yes</u>	<u>No</u>	
a. Too far	<input type="checkbox"/>	<input type="checkbox"/>	<b>CEA11a</b>
b. Participant didn't have time to come in	<input type="checkbox"/>	<input type="checkbox"/>	<b>CEA11b</b>
c. Too sick to come in	<input type="checkbox"/>	<input type="checkbox"/>	<b>CEA11c</b>
d. Lack of transportation	<input type="checkbox"/>	<input type="checkbox"/>	<b>CEA11d</b>
e. Unable to schedule visit within 72 hours (participant)	<input type="checkbox"/>	<input type="checkbox"/>	<b>CEA11e</b>
f. Unable to accommodate visit within 72 hours (clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<b>CEA11f</b>
g. Other	<input type="checkbox"/>	<input type="checkbox"/>	<b>CEA11g</b>
g1. Specify			<b>CEA11g1</b>

ID NUMBER:								
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FORM CODE: **CEA**  
VERSION: **1.0** 05/27/14

Visit  
Number

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SEQ #

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**Call Conclusion Prompt:**

If the participant has not contacted their physician or gone to the emergency room/urgent care and WILL NOT be coming in for a visit:

*“Thank you for contacting us. We recommend that you contact your primary care physician to discuss the worsening symptoms that you are having now and see if he or she recommends treatment.”*

If the participant has not contacted their physician or gone to the emergency room/urgent care and WILL be coming in for a visit:

*“Thank you for contacting us. We recommend that you contact your primary care physician to discuss the worsening symptoms that you are having now and see if he or she recommends treatment. The SPIROMICS visit we’re scheduling now does not take the place of a visit with your physician and is for research evaluation only.”*

If the participant has already contacted their physician or gone to the emergency room/urgent care and WILL be coming in for a visit:

*“Thank you for contacting us. As a reminder, the SPIROMICS visit we’re scheduling now does not take the place of a visit with your physician and is for research evaluation only.”*





ID NUMBER:									
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FORM CODE: **CEF**  
 VERSION: **1.0** 8/13/15

Visit Number		
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SEQ #		
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3) Since the start or worsening of your symptoms, have you experienced any of the following for at least 2 or more consecutive days?

- |   | <u>Yes</u>               | <u>No</u>                |       |
|---|--------------------------|--------------------------|-------|
| a. Runny Nose/Nasal discharge.....      | <input type="checkbox"/> | <input type="checkbox"/> | CEF3a |
| b. Increase or worsening of wheeze..... | <input type="checkbox"/> | <input type="checkbox"/> | CEF3b |
| c. Sore throat.....                     | <input type="checkbox"/> | <input type="checkbox"/> | CEF3c |
| d. Increase or worsening of cough ..... | <input type="checkbox"/> | <input type="checkbox"/> | CEF3d |
| e. Fever .....                          | <input type="checkbox"/> | <input type="checkbox"/> | CEF3e |

**HCU Event Determination**

4. Have you contacted your primary physician or gone to the emergency room, urgent care, or hospital regarding this change in your symptoms?.....  CEF4

Yes ..... 1  
 No ..... 0 → Skip to 4d

4a. Date of contact with physician or emergency room/urgent care visit: // CEF4a

4b. Why did you contact your primary physician or go to the emergency room, urgent care, or hospital for this change in symptoms?

- |   | <u>Yes</u>               | <u>No</u>                |        |
|---|--------------------------|--------------------------|--------|
| 1. Sputum color change: the doctor told me to call if my sputum changes color | <input type="checkbox"/> | <input type="checkbox"/> | CEF4b1 |
| 2. Thought I might need extra treatment                                       | <input type="checkbox"/> | <input type="checkbox"/> | CEF4b2 |
| 3. Knew I needed treatment  | <input type="checkbox"/> | <input type="checkbox"/> | CEF4b3 |
| 4. Scared or nervous  | <input type="checkbox"/> | <input type="checkbox"/> | CEF4b4 |
| 5. Wanted to catch it early   | <input type="checkbox"/> | <input type="checkbox"/> | CEF4b5 |
| 6. Someone (spouse/child) told me to call                                     | <input type="checkbox"/> | <input type="checkbox"/> | CEF4b6 |
| 7. Other  | <input type="checkbox"/> | <input type="checkbox"/> | CEF4b7 |

7a. Specify: CEF4b7a \_\_\_\_\_

4c. Did the participant report going to the emergency room or hospital? ....  CEF4c

Yes ..... 1  
 No ..... 0



ID NUMBER:									
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FORM CODE: CEF  
VERSION: 1.0 8/13/15

Visit Number			SEQ #		
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**Visit Eligibility Determination (Do not read to participant)**

8. Is this participant eligible for an exacerbation clinic visit? .....  **CEF8**  
 Yes ..... 1  
 No ..... 0 → End

*Eligibility Criteria:*

- 1) Fewer than three previous visits (Q7) and
- 2) Participant reports a change in medical treatment (Q4 or Q6 = Y) OR an EXACT trigger (Q1c=Y)
- 3) Participant has contacted the site within 72 hours of the EXACT triggering (CEF1c1), contacting his or her physician (CEF4a), or changing medications (CEF6a), whichever occurred first.

9. Was the participant scheduled for a study visit? .....  **CEF9**  
 Yes ..... 1 → End  
 No ..... 0

10. Reason participant was not scheduled for an exacerbation visit:

	<u>Yes</u>	<u>No</u>
a. Too far	<input type="checkbox"/>	<input type="checkbox"/> <b>CEF10a</b>
b. Participant didn't have time to come in	<input type="checkbox"/>	<input type="checkbox"/> <b>CEF10b</b>
c. Too sick to come in	<input type="checkbox"/>	<input type="checkbox"/> <b>CEF10c</b>
d. Lack of transportation	<input type="checkbox"/>	<input type="checkbox"/> <b>CEF10d</b>
e. Unable to schedule visit within 72 hours (participant)	<input type="checkbox"/>	<input type="checkbox"/> <b>CEF10e</b>
f. Unable to accommodate visit within 72 hours (clinic)	<input type="checkbox"/>	<input type="checkbox"/> <b>CEF10f</b>
g. Other	<input type="checkbox"/>	<input type="checkbox"/> <b>CEF10g</b>
g1. Specify <b>CEF10g1</b>		

ID NUMBER:								
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FORM CODE: **CEF**  
VERSION: **1.0** 8/13/15

Visit  
Number

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SEQ #

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**Call Conclusion Prompt:**

If the participant has not contacted their physician or gone to the emergency room/urgent care and WILL NOT be coming in for a visit:

*“Thank you for contacting us. We recommend that you contact your primary care physician to discuss the worsening symptoms that you are having now and see if he or she recommends treatment.”*

If the participant has not contacted their physician or gone to the emergency room/urgent care and WILL be coming in for a visit:

*“Thank you for contacting us. We recommend that you contact your primary care physician to discuss the worsening symptoms that you are having now and see if he or she recommends treatment. The SPIROMICS visit we’re scheduling now does not take the place of a visit with your physician and is for research evaluation only.”*

If the participant has already contacted their physician or gone to the emergency room/urgent care and WILL be coming in for a visit:

*“Thank you for contacting us. As a reminder, the SPIROMICS visit we’re scheduling now does not take the place of a visit with your physician and is for research evaluation only.”*





ID NUMBER:

FORM CODE: DCF  
VERSION: 1.0 12/15/2014

Visit Number

SEQ #

12b. All listed **ICD-10 Codes** for death: **DCF12B**

1. **DCF12B1**

5. **DCF12B5**

9. **DCF12B9**

2. **DCF12B2**

6. **DCF12B6**

10.

3. **DCF12B3**

7. **DCF12B7**

11.

4. **DCF12B4**

8. **DCF12B8**

12.

13. Are there causes of death recorded on the death certificate? .....  **DCF13A**

Yes .....Y

No.....N→**Go to Item 14**

13a. Immediate cause: **DCF13B**

13b. Due to or as a consequence of (1) **DCF13C**

13c. Due to or as a consequence of (2) **DCF13D**

13d. Due to or as a consequence of (3) **DCF13E**

14. Are there other significant conditions recorded on the death certificate? .....  **DCF14**

Yes .....Y

No.....N→**Go to Item 16**

15. Conditions: **DCF15**

16. Interval between onset and death for immediate cause of death: .....  **DCF16**

- Five minutes or less ..... 1
- One hour or less.....2
- One day or less .....3
- One week or less .....4
- One month or less.....5
- More than one month .....6
- Unknown or Not recorded .....7





# DEMOGRAPHIC INFORMATION FORM

ID NUMBER:

FORM CODE: DEM  
VERSION: 3.0 07/08/11

Visit Number

SEQ #

0a) Form Date: .....   /   /             DEM0A 0b) Staff Code.....

**Instructions:** This form should be completed during the participant's visit. Please read all questions exactly as written.

**This questionnaire gathers demographic information. Please select the answer that is most accurate for you.**

1) What is your birth year?...     DEM01 1a) What is your age? .....   DEM01A

2) What is the highest grade you completed in school? .....   DEM02

- Eighth grade or below ..... 1
- Trade school or business school instead of high school ..... 2
- Some high school ..... 3
- High school graduate ..... 4
- Trade school or business school after graduating high school ..... 5
- Some college ..... 6
- Received bachelor's degree ..... 7
- Graduate or professional education beyond the bachelor's degree ..... 8
- Graduate or professional degree ..... 9
- Specify: DEM02A \_\_\_\_\_
- Declines to answer ..... 10

3) What is your current marital status? .....  DEM03

- Never Married ..... 1
- Married/Living as Married/Living with Partner ..... 2
- Widowed ..... 3
- Separated ..... 4
- Divorced ..... 5
- Declines to answer ..... 6

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: DEM  
VERSION: 3.0 7/08/11

Visit  
Number

SEQ #

- 4) What is your total yearly household income?.....  DEM04
- Under \$15,000..... 1
  - \$15,000 - \$34,999..... 2
  - \$35,000 - \$49,999..... 3
  - \$50,000 - \$74,999..... 4
  - \$75,000 or more ..... 5
  - Declines to answer ..... 6

- 5a) Are you of Hispanic or Latino heritage?.....  DEM05
- Hispanic or Latino (of Spanish culture or origin regardless of race) .....1
  - Not Hispanic or Latino .....2→Skip 5b

5b) Which of the following best describes your Hispanic/Latino heritage? (select only one) DEM05A

- Central American or Central American descent
- Cuban or Cuban descent
- Mexican or Mexican descent
- Puerto - Rican or Puerto Rican descent
- South American or South American descent
- Dominican or Dominican descent
- More than one heritage
- Other

If other, please specify: DEM05A1

6) Which of the following categories would you use to describe yourself? You may select more than one. (check all that apply):

Caucasian/White .....  DEM06A

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American .....  DEM06B

A person having origins in any of the black racial groups of Africa.

Asian .....  DEM06C

A person having origins in any of the original peoples of the Far East, Southeast Asia including the Philippine Islands, or the Indian subcontinent.

American Indian or Alaska Native .....  DEM06D

A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliations or community attachment.

Native Hawaiian or Other Pacific Islander.....  DEM06E

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Participant refused to answer .....  DEM06F



# DEMOGRAPHIC INFORMATION FORM

ID NUMBER:

FORM CODE: DEM  
VERSION: 2.0 11/09/10

Visit Number

SEQ #

0a) Form Date:.....   /   /                  DEM0A 0b) Initials.....

**Instructions:** This form should be completed during the participant's visit. Please read all questions exactly as written.

**This questionnaire gathers demographic information. Please select the answer that is most accurate for you.**

1) What is your birth year?...       DEM01 1a) What is your age? .....   DEM01A

2) What is the highest grade you completed in school? .....   DEM02

- Eighth grade or below..... 1
- Trade school or business school instead of high school ..... 2
- Some high school ..... 3
- High school graduate..... 4
- Trade school or business school after graduating high school..... 5
- Some college ..... 6
- Received bachelor's degree ..... 7
- Graduate or professional education beyond the bachelor's degree 8
- Graduate or professional degree ..... 9

Specify:  \_\_\_\_\_

Declines to answer ..... 10

3) What is your current marital status? .....  DEM03

- Never Married..... 1
- Married ..... 2
- Widowed ..... 3
- Separated ..... 4
- Divorced ..... 5
- Declines to answer ..... 6

ID NUMBER:

FORM CODE: DEM  
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- 4) What is your total yearly household income?  DEM04
- Under \$15,000 ..... 1
  - \$15,000 - \$34,999 ..... 2
  - \$35,000 - \$49,999 ..... 3
  - \$50,000 - \$74,999 ..... 4
  - \$75,000 or more ..... 5
  - Declines to answer ..... 6

- 5a) Are you of Hispanic or Latino heritage?  DEM05
- Hispanic or Latino (of Spanish culture or origin regardless of race) ..... 1
  - Not Hispanic or Latino ..... 2 → Skip 5b

5b) Which of the following best describes your Hispanic/Latino heritage? (select only one) DEM05A

- Central American or Central American descent
- Cuban or Cuban descent
- Mexican or Mexican descent
- Puerto - Rican or Puerto Rican descent
- South American or South American descent
- Dominican or Dominican descent
- More than one heritage
- Other

If other, please specify: DEM05A1 \_\_\_\_\_

6) Which of the following categories would you use to describe yourself? You may select more than one. (check all that apply):

Caucasian/White  DEM06A  
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American  DEM06B  
A person having origins in any of the black racial groups of Africa.

Asian.....  DEM06C  
A person having origins in any of the original peoples of the Far East, Southeast Asia including the Philippine Islands, or the Indian subcontinent.

American Indian or Alaska Native  DEM06D  
A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliations or community attachment.

Native Hawaiian or Other Pacific Islander .....  DEM06E  
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Participant refused to answer .....  DEM06F



# DEMOGRAPHIC INFORMATION FORM

ID NUMBER: **BLINDID** [ ] [ ] [ ] [ ] [ ] [ ]

FORM CODE: DEM  
VERSION: 1.0 10/26/10

Visit Number **VISIT**

SEQ # [ ] [ ] [ ]

0a) Form Date: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] **DEM0A** 0b) Initials [ ] [ ] [ ]

**Instructions:** *This form should be completed during the participant's visit. Please read all questions exactly as written.*

**This questionnaire gathers demographic information. Please select the answer that is most accurate for you.**

- 1) What is your birth year? [ ] [ ] [ ] [ ] **DEM01**      1a) What is your age? [ ] [ ] **DEM01A**
- 2) What is the highest grade you completed in school? [ ] [ ] **DEM02**
- Eighth grade or below ..... 1
  - Trade school or business school instead of high school ..... 2
  - Some high school ..... 3
  - High school graduate ..... 4
  - Trade school or business school after graduating high school ..... 5
  - Some college ..... 6
  - Received bachelor's degree ..... 7
  - Graduate or professional education beyond the bachelor's degree ..... 8
  - Graduate or professional degree ..... 9
  - Specify: **DEM02A** \_\_\_\_\_
  - Declines to answer ..... 10
- 3) What is your current marital status? [ ] **DEM03**
- Never Married ..... 1
  - Married ..... 2
  - Widowed ..... 3
  - Separated ..... 4
  - Divorced ..... 5
  - Declines to answer ..... 6
- 4) What is your total yearly household income? [ ] **DEM04**
- Under \$15,000 ..... 1
  - \$15,000 - \$34,999 ..... 2
  - \$35,000 - \$49,999 ..... 3
  - \$50,000 - \$74,999 ..... 4
  - \$75,000 or more ..... 5
  - Declines to answer ..... 6

ID NUMBER:									
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FORM CODE: DEM  
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SEQ #			
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5) Are you of Hispanic or Latino heritage?.....  DEM05  
Hispanic or Latino (of Spanish culture or origin regardless of race) .....1  
Not Hispanic or Latino .....2

6) Which of the following categories would you use to describe yourself? You may select more than one.  
(check all that apply):

Caucasian/White .....  DEM06A  
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American .....  DEM06B  
A person having origins in any of the black racial groups of Africa.

Asian .....  DEM06C  
A person having origins in any of the original peoples of the Far East, Southeast Asia including the Philippine Islands, or the Indian subcontinent.

American Indian or Alaska Native .....  DEM06D  
A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliations or community attachment.

Native Hawaiian or Other Pacific Islander.....  DEM06E  
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.



# SPIROMICS DIABETES ABSTRACTION FORM (DMF)

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FORM CODE: DMF VERSION:A 2/19/2015	Visit Number	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
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0a. Completion Date: // **DMF0A**      0b. Staff ID:  **DMF0B**  
Month/Day/Year

0c. Event ID:  **DMF0C**      0d. Event Date: // **DMF0D**

Instructions: *Answers are derived from the medical records received. Do not complete this form until all records are received or classified as unobtainable as indicated on the Medical Record Shipping Form.*

## A. GENERAL INFORMATION

- Was the event (*choose one*):  **DMF1**  
 1= In hospital only      2= Emergency Dept. visit only (ED)      3= Both ED and in hospital
- Date of admission: (mm/dd/yyyy) // **DMF2**
- Date of discharge: (mm/dd/yyyy) // **DMF3**
- What was the primary admitting diagnosis code? . **DMF4**
- What was the primary discharge diagnosis code? . **DMF5**

## B. DIAGNOSIS AND VALUES

- Type of Diabetes Mellitus diagnosed: (*Mark only one*) **DMF6**  
 a.  Type 1  
 b.  Type 2
- First measured weight available: . **DMF7**      1= Lbs 2= Kgs:  **DMF7A**
- Height: . **DMF8**      1= Inches 2= Centimeters:  **DMF8A**
- BMI: . **DMF9**
- Most recent A1c test result: (*Mark only one; may use pre-hospitalization value recorded by a physician*) **DMF10**  
 a.  < 5.7%  
 b.  5.7 – 6.4%  
 c.  > 6.4%

ID NUMBER:							
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FORM CODE: DMF  
VERSION: A 2/19/2015

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Number

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11. Most recent fasting glucose test result: *(Mark only one; may use pre-hospitalization value recorded by a physician)*

- a.  ≤ 100 mg/dl  
b.  > 101 mg/dl

**DMF11**

**C. CONTRIBUTING HISTORY**

12. Patient's contributing health history: *(Mark any that apply)*

- a.  Pancreatitis **DMF12A**  
b.  Pancreatic carcinoma **DMF12B**  
c.  Pancreatectomy **DMF12C**  
d.  Endocrinopathy (Cushing's disease, pheochromocytoma) **DMF12D**  
e.  None/Not Recorded **DMF12E**  
f.  Other, specify \_\_\_\_\_ **DMF12F**

**D. SEQUELAE OF DIABETES**

13. Health impacts from Diabetes: *(Mark all that apply)*

- a.  Diabetic nephropathy **DMF13A**  
    1.  Diagnosis of renal failure of any severity **DMF13A1**  
    2.  Patient is on dialysis **DMF13A2**  
b.  Peripheral Neuropathy **DMF13B**  
    1.  Non-healing ulcers **DMF13B1**  
    2.  Lower extremity amputation (toe, forefoot, heel, below the knee) **DMF13B2**  
    3.  Charcot joint **DMF13B3**  
c.  Eye complications **DMF13C**  
    1.  Retinopathy **DMF13C1**  
    2.  Glaucoma **DMF13C2**  
    3.  Cataracts **DMF13C3**  
    4.  Macular edema **DMF13C4**  
d.  Gastrointestinal complications **DMF13D**  
    1.  Gastroparesis **DMF13D1**  
    2.  Diabetic diarrhea **DMF13D2**  
    3.  Candidiasis **DMF13D3**  
e.  Cardiovascular / Atherosclerotic complications **DMF13E**  
    1.  Cardiovascular disease **DMF13E1**  
    2.  Peripheral vascular disease **DMF13E2**  
    3.  Cerebrovascular disease **DMF13E3**

**E. TREATMENT**

14. Medications: *(Mark all that apply)*

- a.  Oral Sulfonylureas (Glipizide, Glyburide, Glimepiride)  
b.  Oral Glinides (GlucNorm, Starlix)  
c.  Oral DDP-4 inhibitors (Januvia, Onglyza)  
d.  Oral GPL analogs (Victoza, Byetta)  
e.  Oral Metformin  
f.  Injectable Insulin

Admission

Discharge

- DMF14A1**  
 **DMF14B1**  
 **DMF14C1**  
 **DMF14D1**  
 **DMF14E1**  
 **DMF14F1**

- DMF14A2**  
 **DMF14B2**  
 **DMF14C2**  
 **DMF14D2**  
 **DMF14E2**  
 **DMF14F2**





# EXACERBATION ASSESSMENT FORM

ID NUMBER:	<input type="text" value="BLINDID"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: **EAF**  
 VERSION: 1.0 05/27/14

Visit  
Number

<input type="text" value="visit"/>	<input type="text"/>
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SEQ #

<input type="text"/>	<input type="text"/>
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0a) Form Completion Date.... //   0b) Staff Code .....

**Instructions:** This form should be completed when a participant comes to the clinical center for an exacerbation study visit. This form should be completed before proceeding with the rest of the study visit.

### Administrative Information

1) Date of clinic visit: /

2) What type of Event is this? .....

Participant/HCU-triggered..... 1  
 Symptom/EXACT-Triggered ..... 2

### Examination (completed by Coordinator):

3) Temperature . °C

4) Weight . kg

5) Pulse  min<sup>-1</sup>

6) SpO2  %

7) Notes:

ID NUMBER:									
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FORM CODE: **EAF**  
 VERSION: **1.0** 5/23/13

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**Participant Interview (completed by Coordinator):**

8) Have you had any changes to your **respiratory** medications related to this event (this includes new prescriptions or self-medication)? .....  **EAF8**

Yes ..... 1

No ..... 0 → **Go to 12**

Please specify type of medication for this event by checking the appropriate box:

9) MEDICATION	Date Prescribed	Duration (Days)
a1) Antibiotic 1: <b>EAF9a1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9a1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9a1b</b>
a2) Antibiotic 2: <b>EAF9a2</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9a2a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9a2b</b>
b1) Inhaled corticosteroids: <b>EAF9b1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9b1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9b1b</b>
c1) Inhaled corticosteroids w/long-acting $\beta_2$ -agonists: <b>EAF9c1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9c1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9c1b</b>
d1) Aminophyllines: <b>EAF9d1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9d1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9d1b</b>
e1) $\beta_2$ -agonists Short-Acting: <b>EAF9e1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9e1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9e1b</b>
f1) $\beta_2$ -agonists Long-Acting: <b>EAF9f1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9f1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9f1b</b>
g1) Short-acting anticholinergic <b>EAF9g1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9g1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9g1b</b>
h1) Long-acting anticholinergic <b>EAF9h1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9h1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9h1b</b>
i1) Short-acting $\beta_2$ -agonists/anticholinergic: <b>EAF9i1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9i1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9i1b</b>
j1) Long-acting $\beta_2$ -agonists/anticholinergic: <b>EAF9j1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9j1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9j1b</b>
k1) Roflumilast (Daxas, Daliresp) (Y/N): <input type="checkbox"/> <b>EAF9k1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9k1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9k1b</b>
l1) Leukotriene antagonists: <b>EAF9l1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9l1a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9l1b</b>
m1) Other Medications: (Y/N): <input type="checkbox"/> <b>EAF9m1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF9m1b</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF9m1c</b>
Specify: <b>EAF9m1a</b>		

10) TREATMENTS	Date Prescribed	Duration (Days)
a) Pulmonary Rehabilitation (Y/N): <input type="checkbox"/> <b>EAF10a</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF10a1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF10a2</b>
b) Supplemental Oxygen (Y/N): <input type="checkbox"/> <b>EAF10b</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF10b1</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF10b2</b>
c) Other Clinical Treatments (Y/N): <input type="checkbox"/> <b>EAF10c</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <b>EAF10c2</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>EAF10c3</b>
Specify: <b>EAF10c1</b>		

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11) Have you had a new or changed prescription for oral steroids as a result of the change in your respiratory symptoms?  **EAF11**

Yes ..... 1

No ..... 0 → **Go to 12**

11a) What type of oral steroids were prescribed? **EAF11a**

11a1) Specify: **EAF11a1**

11b) What date were the oral steroids prescribed?   /   /    **EAF11b**

11c) What is the duration of this prescription?    days **EAF11c**

11d) What was the total dosage of oral steroids prescribed?    mg **EAF11d**

12) Have you taken any pain medications such as aspirin, Advil, Aleve, or Tylenol?  **EAF12**

Yes ..... 1

No ..... 0 → **Go to 13**

12a) Pain medicine 1: **EAF12a**

12a1) Specify: **EAF12a1**

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <b>EAF12a2</b>	<b>EAF12a3</b>	<b>EAF12a4</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>EAF12a5</b>

12b) Pain medicine 2: **EAF12b**

12b1) Specify: **EAF12b1**

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <b>EAF12b2</b>	<b>EAF12b3</b>	<b>EAF12b4</b>	<input type="text"/> <input type="text"/> <input type="text"/> <b>EAF12b5</b>

12c) Pain medicine 3: **EAF12c**

ID NUMBER:									
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12c1) Specify: EAF12c1

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
□□/□□/□□ <span style="border: 1px solid red; padding: 2px;">EAF12c2</span>	<span style="border: 1px solid red; padding: 2px;">EAF12c3</span>	<span style="border: 1px solid red; padding: 2px;">EAF12c4</span>	□□□ <span style="border: 1px solid red; padding: 2px;">EAF12c5</span>

12d) Pain medicine 4: EAF12d

12d1) Specify: EAF12d1

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
□□/□□/□□ <span style="border: 1px solid red; padding: 2px;">EAF12d2</span>	<span style="border: 1px solid red; padding: 2px;">EAF12d3</span>	<span style="border: 1px solid red; padding: 2px;">EAF12d4</span>	□□□ <span style="border: 1px solid red; padding: 2px;">EAF12d5</span>

**Review of Symptoms (Completed by Coordinator)**

13) How serious is this flare-up/exacerbation compared to previous flare ups/exacerbations?  EAF13

- More serious ..... 1
- As serious ..... 2
- Less serious ..... 3
- Never had an exacerbation before ..... 4

14) Since the start or worsening of your symptoms, have you experienced any of the following for at least 2 or more consecutive days?

	Yes	No	
a) Increase or Worsening in Shortness of Breath (Dyspnea) .....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF14a</span>
b) Change in sputum color (purulence).....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF14b</span>
c) Increase in sputum volume.....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF14c</span>

15) Since the start or worsening of your symptoms, have you experienced any of the following for at least 2 or more consecutive days?

	Yes	No	
a) Runny Nose/Nasal discharge .....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF15a</span>
b) Increase or worsening of Wheeze .....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF15b</span>
c) Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF15c</span>
d) Increase or worsening of Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF15d</span>
e) Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<span style="border: 1px solid red; padding: 2px;">EAF15e</span>

16) Have you had any OTHER **new** Symptoms related to this event?  EAF16

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Yes..... 1

No ..... 0 → **Go to 17**

- a) Symptom 1: EAF16a \_\_\_\_\_
- b) Symptom 2: EAF16b \_\_\_\_\_
- c) Symptom 3: EAF16c \_\_\_\_\_
- d) Symptom 4: EAF16d \_\_\_\_\_
- e) Symptom 5: EAF16e \_\_\_\_\_
- f) Symptom 6: EAF16f \_\_\_\_\_
- g) Symptom 7: EAF16g \_\_\_\_\_
- h) Symptom 8: EAF16h \_\_\_\_\_
- i) Symptom 9: EAF16i \_\_\_\_\_
- j) Symptom 10: EAF16j \_\_\_\_\_

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FORM CODE:  **EAF**   
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**Physician Assessment**

**17) Wheezes:** EAF17

- Yes
- No

**18) Crackles:** EAF18

- Yes
- No

**19) Gallop:** EAF19

- Yes
- No

**20) Edema:** EAF20

- Yes
- No

21) Were other conditions present at the time of this event? (Y/N)  → If no skip to 23 EAF21

22) If yes, please specify the conditions present:

**a) Pneumonia:** EAF22a

- Yes
- No → Go to 22c

**b) Pneumonia confirmed by:**

- Chest film EAF22b
- Clinical examination
- Both

**c) Congestive Heart Failure:** EAF22c

- Yes
- No

**d) Other:** EAF22d

- Yes
  - No
- Specify: EAF22d1 \_\_\_\_\_

**e) Other:** EAF22e

- Yes
  - No
- Specify: EAF22e1 \_\_\_\_\_

**f) Other:** EAF22f

- Yes
  - No
- Specify: EAF22f1 \_\_\_\_\_

**23) Diagnosis of a COPD exacerbation:** EAF23

- Yes
- No → Skip to Q29

**24) Exacerbation severity:** EAF24

- Mild
- Moderate
- Severe
- Very Severe

**25) Duration to date:** EAF25

- Less than 1 Day
- 1-2 Days
- 3-5 Days
- 1 Week
- More than 1 Week
- Unknown

**26) Potential Etiology** EAF26

- Infectious (answer Q27)
- Weather
- Treatment Non-Compliance
- Air pollution
- Unknown

**27) Potential Infectious Etiology:** EAF27

- Viral
- Bacterial
- Unknown
- Other (specify): EAF27a \_\_\_\_\_

**28) Participant to proceed with exacerbation visit?** EAF28

- Yes → END
  - No
    - Not COPD exacerbation
    - Outside of visit window (> 72 hrs)
    - Other EAF28a
- Specify: EAF28a \_\_\_\_\_
- END (Do not proceed to Q29 or 30)

**29) If not a COPD exacerbation, what:** EAF29

- Lack of symptomatic criteria
  - Upper respiratory tract infection
  - Change in comorbid condition → Go to Q28
  - Other EAF29a
- Specify: \_\_\_\_\_

**30) Change(s) in what comorbid condition (s)?** EAF30

- Cardiovascular (Angina, CHF, etc)
  - Neurological
  - Other EAF30a
- Specify: \_\_\_\_\_



ID NUMBER:

FORM CODE: **ECA**  
VERSION: 1.0  
6/11/14

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5b. If Yes, how many regular cigarettes do you smoke a day:    **ECA5B**

5c. Has your use of eCigarettes decreased the number of regular cigarettes you smoke each day?.....  **ECA5C**

Yes..... 1  
No ..... 0 → **Go to Q6**

5c1. If **Yes**, about how many *fewer* cigarettes a day do you now smoke?    **ECA5C1**

6. How often do you smoke eCigarettes?.....  **ECA6**

Every day ..... 1  
Most days (4+ days a week) ..... 2  
Some days (1-3 days a week) .. 3  
Less than once a week ..... 4  
Less than once a month ..... 5

7. When did you last smoke an eCigarette?.....  **ECA7**

Within the last hour..... 1  
Sometime today ..... 2  
Yesterday ..... 3  
Within the last week ..... 4  
Within the last month ..... 5  
More than a month ago ..... 6

8. In the last 24 hours, how many times have you smoked an eCigarette? .....   **ECA8** times

9. What brand of eCigarette do you now smoke?.....  **ECA9A**

blu ..... 1  
Henley ..... 2  
Joye ..... 3  
NJOY ..... 4  
V2 ..... 5  
Other ..... 6  
Specify: **ECA9B** \_\_\_\_\_



ID NUMBER:

Visit Number   SEQ #

10. What cartridge size do you use most often with your eCigarettes?.....  ECA10A

- 0 mg..... 1
- 6-8 mg..... 2
- 9-12 mg..... 3
- 13-16 mg..... 4
- Do not know ..... 5
- Other..... 6

Specify:   mg ECA10B

11. In one week, how many eCigarette cartridges do you use?   cartridges ECA11

12. Did you start smoking eCigarettes because you wanted to cut down or stop smoking regular cigarette?.....  ECA12

- Yes..... 1
- No ..... 0

13. Did you start smoking eCigarettes because you wanted to improve your health?.....  ECA13

- Yes..... 1
- No ..... 0

Answer the following questions only if you no longer smoke eCigarettes (i.e., Question 4= N)

14. If **No**, for how long did you smoke eCigarettes?

ECA14A  ECA14B  ECA14C  
 days  months  years

15. How long has it been since you smoked an eCigarette?

ECA15A  ECA15B  ECA15C  
 days  months  years

16. When you did smoke eCigarettes, how often did you smoke eCigarettes?.....  ECA16

- Every day ..... 1
- Most days..... 2
- 4+ days a week ..... 3
- 1-3 days a week ..... 4

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Less than once a week..... 5  
Less than once a month ..... 6

17. What brand of eCigarette did you usually smoke? .....  ECA17

- blu ..... 1
- Henley ..... 2
- Joye ..... 3
- NJOY ..... 4
- V2 ..... 5
- Other ..... 6

Specify:  ECA17A \_\_\_\_\_

18. What cartridge size did you use most often with your eCigarettes? .....  ECA18A

- 0 mg ..... 1
- 6-8 mg ..... 2
- 9-12 mg ..... 3
- 13-16 mg ..... 4
- Do not know ..... 5
- Other ..... 6

Specify:   mg  ECA18B

19. On average, in one week, how many eCigarette cartridges did you use?   cartridges  ECA19



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4. Do you still smoke eCigarettes? .....  **ECF4**

Yes..... 1

No ..... 0 → **Go to Q14**

5. Do you still smoke regular tobacco cigarettes? .....  **ECF5A**

Yes..... 1

No ..... 0 → **Go to Q6**

5b. If Yes, how many regular cigarettes do you smoke a day:  **ECF5B**

5c. Has your use of eCigarettes decreased the number of regular cigarettes you smoke each day?.....  **ECF5C**

Yes..... 1

No ..... 0 → **Go to Q6**

5c1. If **Yes**, about how many *fewer* cigarettes a day do you now smoke?  **ECF5C1**

6. How often do you smoke eCigarettes? .....  **ECF6**

Every day ..... 1

Most days..... 2

4+ days a week ..... 3

1-3 days a week ..... 4

Less than once a week..... 5

Less than once a month ..... 6

7. When did you last smoke an eCigarette? .....  **ECF7**

Within the last hour..... 1

Sometime today ..... 2

Yesterday ..... 3

Within the last week ..... 4

Within the last month ..... 5

More than a month ago ..... 6

8. In the last 24 hours, how many times have you smoked an

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eCigarette? .....   times **ECF8**

9. What brand of eCigarette do you now smoke?.....  **ECF9A**

- blu ..... 1
  - Henley ..... 2
  - Joye ..... 3
  - NJOY ..... 4
  - V2 ..... 5
  - Other ..... 6
- Specify: **ECF9B** \_\_\_\_\_

10. What cartridge size do you use most often with your eCigarettes?.....  **ECF10A**

- 0 mg ..... 1
  - 6-8 mg ..... 2
  - 9-12 mg ..... 3
  - 13-16 mg ..... 4
  - Do not know ..... 5
  - Other ..... 6
- Specify:   mg **ECF10B**

11. In one week, how many eCigarette cartridges do you use?   cartridges **ECF11**

12. Did you start smoking eCigarettes because you wanted to cut down or stop smoking regular cigarettes? .....  **ECF12**

- Yes..... 1
- No ..... 0

13. Did you start smoking eCigarettes because you wanted to improve your health?.....  **ECF13**

- Yes..... 1
- No ..... 0

*Answer the following questions only if you no longer smoke eCigarettes (i.e., Question 4= N)*

14. If **No**, for how long did you smoke eCigarettes?

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**ECF14A**  days  **ECF14B**  months  **ECF14C**  years

15. How long has it been since you smoked an eCigarette?

**ECF15A**  days  **ECF15B**  months  **ECF15C**  years

16. When you did smoke eCigarettes, how often did you smoke

eCigarettes?.....  **ECF16**

- Every day ..... 1
- Most days..... 2
- 4+ days a week ..... 3
- 1-3 days a week ..... 4
- Less than once a week..... 5
- Less than once a month ..... 6

17. What brand of eCigarette did you usually smoke?.....  **ECF17**

- blu ..... 1
- Henley ..... 2
- Joye ..... 3
- NJOY ..... 4
- V2 ..... 5
- Other ..... 6

Specify: **ECF17A** \_\_\_\_\_

18. What cartridge size did you use most often with your eCigarettes?.....  **ECF18A**

- 0 mg ..... 1
- 6-8 mg ..... 2
- 9-12 mg ..... 3
- 13-16 mg ..... 4
- Do not know ..... 5
- Other ..... 6

Specify:  mg **ECF18B**

19. On average, in one week, how many eCigarette cartridges did

you use?  cartridges **ECF19**



## EXACERBATION RESOLUTION FORM

ID NUMBER: BLINDID

FORM CODE: ERF  
VERSION: 1.0 08/9/13

Visit Number visit SEQ #

0a) Form Date: .....   /   /        EEF0a    0b) Initials .....    EEF0b

**Instructions:** *Twenty-eight days after the HCU exacerbation visit in Wave 1, contact the participant to determine whether exacerbation symptoms have resolved. If the symptoms have not resolved, contact the participant again in seven days. Repeat contacts every seven days until symptoms resolve OR more than 56 days have elapsed since the HCU exacerbation visit. When the participant reports his/her symptoms have resolved or more than 56 days have elapsed since the visit, the PDA must be updated to allow symptom-driven event triggering.*

A. Date of contact	B. Result Code	C. <b>Prompt:</b> Have you recovered from your exacerbation/flare-up?	D. If no: Date of next scheduled call
1) <span style="border: 1px solid black; padding: 2px;">EEF1a</span>	<span style="border: 1px solid black; padding: 2px;">EEF1b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF1c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF1d</span>
2) <span style="border: 1px solid black; padding: 2px;">EEF2a</span>	<span style="border: 1px solid black; padding: 2px;">EEF2b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF2c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF2d</span>
3) <span style="border: 1px solid black; padding: 2px;">EEF3a</span>	<span style="border: 1px solid black; padding: 2px;">EEF3b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF3c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF3d</span>
4) <span style="border: 1px solid black; padding: 2px;">EEF4a</span>	<span style="border: 1px solid black; padding: 2px;">EEF4b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF4c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF4d</span>
5) <span style="border: 1px solid black; padding: 2px;">EEF5a</span>	<span style="border: 1px solid black; padding: 2px;">EEF5b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF5c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF5d</span>
6) <span style="border: 1px solid black; padding: 2px;">EEF6a</span>	<span style="border: 1px solid black; padding: 2px;">EEF6b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF6c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF6d</span>
7) <span style="border: 1px solid black; padding: 2px;">EEF7a</span>	<span style="border: 1px solid black; padding: 2px;">EEF7b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF7c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF7d</span>
8) <span style="border: 1px solid black; padding: 2px;">EEF8a</span>	<span style="border: 1px solid black; padding: 2px;">EEF8b</span>	Yes <input type="checkbox"/> No <input type="checkbox"/> <span style="border: 1px solid black; padding: 2px;">EEF8c</span>	<span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> / <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> <span style="border: 1px solid black; padding: 2px;">EEF8d</span>

- Result codes:**
- Contacted, call complete ..... A → Go to 9
  - Contacted, asked to call back ..... B
  - Reported alive, not available ..... C
  - Reported alive, too sick to complete call ..... D
  - Reported alive, in hospital ..... E
  - Reported alive, proxy answered questions .. F
  - No answer ..... G





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6) Approximately what date did you begin working in this job? ..... /  (MM/YYYY) **EHA6**

7) On average, how many hours per week do you work? .....  **EHA7**

8) Does your current job expose you to vapors, gas, dust, or fumes? .....  **EHA8**

- Yes..... Y
- No ..... N
- Don't know ..... U

*I'm now going to ask you a few questions about the last job you had.*

9) Did you leave your last job because of breathing or lung problems? .....  **EHA9**

- Yes..... Y
- No ..... N
- No Answer/Don't know ..... U

10) Did your last job expose you to vapors, gas, dust or fumes? .....  **EHA10**

- Yes..... Y
- No ..... N
- Don't know ..... U

11) Are you no longer working at your last job at least in part to avoid the things that caused you difficulty breathing, such as air quality, temperature, or physical exertion? .....  **EHA11**

- Yes..... Y
- No ..... N
- Don't know ..... U

12) Thinking back to where you were last employed, did you stop working there, at least in part, because of missed time due to illness ? .....  **EHA12**

- Yes..... Y
- No ..... N
- Don't know ..... U

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*I'm now going to ask you a series of questions that might describe your current job. [Questions 13-15 should only be answered by participants who answered Started a new job in the past 12 months in Question 2]*

13) Do you now work:	Yes	No	How many months?
a) in a cotton, flax or hemp mill? .....	<input type="checkbox"/> EHA13A	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13A1
b) in a foundry? .....	<input type="checkbox"/> EHA13B	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13B1
c) in a glass works? .....	<input type="checkbox"/> EHA13C	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13C1
d) in a mine? .....	<input type="checkbox"/> EHA13D	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13D1
e) in a pottery? .....	<input type="checkbox"/> EHA13E	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13E1
f) in a power plant? .....	<input type="checkbox"/> EHA13F	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13F1
g) in a quarry? .....	<input type="checkbox"/> EHA13G	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13G1
h) in a refinery? .....	<input type="checkbox"/> EHA13H	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13H1
i) or with asbestos? .....	<input type="checkbox"/> EHA13I	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13I1
j) in synthetic fibers or fabric manufacturing? .....	<input type="checkbox"/> EHA13J	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13J1
k) in a paper mill? .....	<input type="checkbox"/> EHA13K	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13K1
l) in building or highway construction? .....	<input type="checkbox"/> EHA13L	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13L1
m) in an aluminum factory? .....	<input type="checkbox"/> EHA13M	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13M1
n) in a rubber tire plant? .....	<input type="checkbox"/> EHA13N	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13N1
o) in HVAC? .....	<input type="checkbox"/> EHA13O	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13O1
p) in demolition? .....	<input type="checkbox"/> EHA13P	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13P1
q) in remodeling? .....	<input type="checkbox"/> EHA13Q	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13Q1
r) in professional cleaning? .....	<input type="checkbox"/> EHA13R	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13R1
s) in beauty care? .....	<input type="checkbox"/> EHA13S	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13S1
t) in agriculture? .....	<input type="checkbox"/> EHA13T	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13T1
u) in the flooring industry? .....	<input type="checkbox"/> EHA13U	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA13U1

14) Do you now work as:	Yes	No	How many months?
a) a boilermaker? .....	<input type="checkbox"/> EHA14A	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14A1
b) a carpenter? .....	<input type="checkbox"/> EHA14B	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14B1
c) a chemical worker? .....	<input type="checkbox"/> EHA14C	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14C1
d) an electrician? .....	<input type="checkbox"/> EHA14D	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14D1
e) an elevator operator? .....	<input type="checkbox"/> EHA14E	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14E1
f) an insulator? .....	<input type="checkbox"/> EHA14F	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14F1
g) a lather? .....	<input type="checkbox"/> EHA14G	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14G1
h) a machinist? .....	<input type="checkbox"/> EHA14H	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14H1
i) a mechanic? .....	<input type="checkbox"/> EHA14I	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14I1
j) a millwright? .....	<input type="checkbox"/> EHA14J	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14J1
k) a pipefitter? .....	<input type="checkbox"/> EHA14K	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14K1
l) a plasterer? .....	<input type="checkbox"/> EHA14L	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14L1
m) a plumber? .....	<input type="checkbox"/> EHA14M	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14M1
n) a sander? .....	<input type="checkbox"/> EHA14N	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA14N1

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- |                                | Yes                             | No                       | How many months?   |  |  |  |
|--------------------------------|---------------------------------|--------------------------|--|--|--|--|
| o) a sheet metal worker? ..... | <input type="checkbox"/> EHA14O | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14O1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| p) a steelworker? .....        | <input type="checkbox"/> EHA14P | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14P1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| q) a welder? .....             | <input type="checkbox"/> EHA14Q | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14Q1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| r) a pig farmer? .....         | <input type="checkbox"/> EHA14R | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14R1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| s) a rigger? .....             | <input type="checkbox"/> EHA14S | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14S1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| t) a roofer? .....             | <input type="checkbox"/> EHA14T | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14T1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| u) a painter? .....            | <input type="checkbox"/> EHA14U | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14U1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| v) a mason? .....              | <input type="checkbox"/> EHA14V | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA14V1 |  |  |  |
|                                |                                 |                          |  |  |  |  |

15) In your job, do you come into regular contact with any of the following specific examples of vapors, gas, dust or fumes?

- |   | Yes                             | No                       | How many months?   |  |  |  |
|---|---------------------------------|--------------------------|--|--|--|--|
| a) Irritant gases, such as chlorine or ammonia.....         | <input type="checkbox"/> EHA15A | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15A1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| b) Fire, smoke or other combustion products .....           | <input type="checkbox"/> EHA15B | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15B1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| c) Incinerators, boilers, or oil refineries .....           | <input type="checkbox"/> EHA15C | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15C1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| d) Coal dust or powder.....                                 | <input type="checkbox"/> EHA15D | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15D1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| e) Silica or sand, or concrete, cement, or rock dust .....  | <input type="checkbox"/> EHA15E | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15E1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| f) Indoor fuel powered motors, compressors, or engines..... | <input type="checkbox"/> EHA15F | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15F1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| g) Diesel engine exhaust .....                              | <input type="checkbox"/> EHA15G | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15G1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| h) Wheat flour or other grain dusts.....                    | <input type="checkbox"/> EHA15H | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15H1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| i) Animal feeds or fodder.....                              | <input type="checkbox"/> EHA15I | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15I1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| j) Cotton dust or cotton processing .....                   | <input type="checkbox"/> EHA15J | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15J1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| k) Wood dust or saw dust .....                              | <input type="checkbox"/> EHA15K | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15K1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| l) Cadmium fumes or batteries or silver solder .....        | <input type="checkbox"/> EHA15L | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15L1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| m) Other metal dusts or metal fumes .....                   | <input type="checkbox"/> EHA15M | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15M1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| n) Welding or flame cutting .....                           | <input type="checkbox"/> EHA15N | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15N1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| o) Fiberglass or other man-made mineral fibers.....         | <input type="checkbox"/> EHA15O | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15O1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| p) Explosives or blasting fumes .....                       | <input type="checkbox"/> EHA15P | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHA15P1 |  |  |  |
|   |                                 |                          |  |  |  |  |

If Question 13d = Y (that is, history of working in a mine) answer questions 16-17)

In question 13 you indicated you work in a mine.

- 16) Why type of mine is it? .....  EHA16
- Open pit ..... 1
- Underground..... 2
- Other..... 3
- Specify:  EHA16A

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17) What is mined? .....  EHA17

- Hard rock (e.g., lead, zinc, silver, gold, etc) ..... 1
- Uranium ..... 2
- Coal ..... 3
- Other ..... 4
- Specify:  EHA17A \_\_\_\_\_

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18) During your last visit you indicated you worked in the following location(s). We'd like to know for how many years you worked in this(these) location(s). [DO NOT READ: If none are marked skip to question 19]

	Yes	No	How many years?
a) in a cotton, flax or hemp mill? .....	<input type="checkbox"/> EHA18A	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18A1
b) in a foundry? .....	<input type="checkbox"/> EHA18B	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18B1
c) in a glass works? .....	<input type="checkbox"/> EHA18C	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18C1
d) in a mine? .....	<input type="checkbox"/> EHA18D	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18D1
e) in a pottery? .....	<input type="checkbox"/> EHA18E	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18E1
f) in a power plant? .....	<input type="checkbox"/> EHA18F	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18F1
g) in a quarry? .....	<input type="checkbox"/> EHA18G	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18G1
h) in a refinery? .....	<input type="checkbox"/> EHA18H	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18H1
i) or with asbestos? .....	<input type="checkbox"/> EHA18I	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18I1
j) in synthetic fibers or fabric manufacturing? .....	<input type="checkbox"/> EHA18J	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18J1
k) in a paper mill? .....	<input type="checkbox"/> EHA18K	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18K1
l) in building or highway construction? .....	<input type="checkbox"/> EHA18L	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18L1
m) in an aluminum factory? .....	<input type="checkbox"/> EHA18M	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18M1
n) in a rubber tire plant? .....	<input type="checkbox"/> EHA18N	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18N1
o) in HVAC? .....	<input type="checkbox"/> EHA18O	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18O1
p) in demolition? .....	<input type="checkbox"/> EHA18P	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18P1
q) in remodeling? .....	<input type="checkbox"/> EHA18Q	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18Q1
r) in professional cleaning? .....	<input type="checkbox"/> EHA18R	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18R1
s) in beauty care? .....	<input type="checkbox"/> EHA18S	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18S1
t) in agriculture? .....	<input type="checkbox"/> EHA18T	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18T1
u) in the flooring industry? .....	<input type="checkbox"/> EHA18U	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA18U1

19) During your last visit you indicated you worked in the following occupation(s). We'd like to know for how many years you worked in this(these) occupation(s). [DO NOT READ: If none are marked skip to question 20]

	Yes	No	How many years?
a) a boilermaker? .....	<input type="checkbox"/> EHA19A	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19A1
b) a carpenter? .....	<input type="checkbox"/> EHA19B	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19B1
c) a chemical worker? .....	<input type="checkbox"/> EHA19C	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19C1
d) an electrician? .....	<input type="checkbox"/> EHA19D	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19D1
e) an elevator operator? .....	<input type="checkbox"/> EHA19E	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19E1
f) an insulator? .....	<input type="checkbox"/> EHA19F	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19F1
g) a lather? .....	<input type="checkbox"/> EHA19G	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19G1
h) a machinist? .....	<input type="checkbox"/> EHA19H	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19H1
i) a mechanic? .....	<input type="checkbox"/> EHA19I	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19I1
j) a millwright? .....	<input type="checkbox"/> EHA19J	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19J1
k) a pipefitter? .....	<input type="checkbox"/> EHA19K	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19K1
l) a plasterer? .....	<input type="checkbox"/> EHA19L	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19L1
m) a plumber? .....	<input type="checkbox"/> EHA19M	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> EHA19M1

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- n) a sander? ..... EHA19N     EHA19N1
- o) a sheet metal worker? ..... EHA19O     EHA19O1
- p) a steelworker? ..... EHA19P     EHA19P1
- q) a welder? ..... EHA19Q     EHA19Q1
- r) a pig farmer? ..... EHA19R     EHA19R1
- s) a rigger? ..... EHA19S     EHA19S1
- t) a roofer? ..... EHA19T     EHA19T1
- u) a painter? ..... EHA19U     EHA19U1
- v) a mason? ..... EHA19V     EHA19V1

20) During your last visit, you indicated that as part of a job you regularly came into contact with one or more of the following specific examples of vapors, gas, dust or fumes. [DO NOT READ: If none are marked skip to question 21]

- |   | Yes                      | No                       | How many years?  |
|---|--------------------------|--------------------------|--|
| a) Irritant gases, such as chlorine or ammonia.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20A1</span> |
| b) Fire, smoke or other combustion products.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20B1</span> |
| c) Incinerators, boilers, or oil refineries.....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20C1</span> |
| d) Coal dust or powder.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20D1</span> |
| e) Silica or sand, or concrete, cement, or rock dust.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20E1</span> |
| f) Indoor fuel powered motors, compressors, or engines..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20F1</span> |
| g) Diesel engine exhaust.....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20G1</span> |
| h) Wheat flour or other grain dusts.....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20H1</span> |
| i) Animal feeds or fodder.....                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20I1</span> |
| j) Cotton dust or cotton processing.....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20J1</span> |
| k) Wood dust or saw dust.....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20K1</span> |
| l) Cadmium fumes or batteries or silver solder.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20L1</span> |
| m) Other metal dusts or metal fumes.....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20M1</span> |
| n) Welding or flame cutting.....                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20N1</span> |
| o) Fiberglass or other man-made mineral fibers.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20O1</span> |
| p) Explosives or blasting fumes.....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">EHA20P1</span> |

If Question 18d = Y (that is, history of working in a mine) answer questions 21-22)

In question 18 you indicated you have worked in a mine.

- 21) Why type of mine was it? .....  EHA21
- Open pit ..... 1
  - Underground..... 2
  - Other..... 3
- Specify: EHA21A

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22) What was mined?.....  EHA22

- Hard rock (e.g., lead, zinc, silver, gold, etc)..... 1
- Uranium ..... 2
- Coal ..... 3
- Other ..... 4
- Specify: EHA22A





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7) How many years, altogether, did you work in this job? ..... 

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**EHF07**

7a) On average, how many hours per week did you work in this job? ..... 

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**EHF07A**

8) Did you leave your last job because of breathing or lung problems? ..... 

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**EHF08**

- Yes..... Y
- No ..... N
- No Answer/Don't know ..... U

9) Are you not working at least in part to avoid the things that caused you difficulty breathing, such as air quality, temperature, or physical exertion?..... 

--

**EHF09**

- Yes..... Y
- No ..... N
- Don't know ..... U

10) Thinking back to when you were last employed, did you stop working, at least in part, because of missed time due to illness ? ..... 

--

**EHF10**

- Yes..... Y
- No ..... N
- Don't know ..... U

11) Did this job expose you to vapors, gas, dust or fumes?..... 

--

**EHF11**

- Yes..... Y
- No ..... N
- Don't know ..... U

12) Was this work the longest job that you have ever held? ..... 

--

**EHF12**

- Yes..... Y → **Go to Item 18**
- No ..... N
- Don't know ..... U → **Go to Item 18**

a) In your longest held job, what kind of work did you do? That is, what was your occupation?  
Occupation: **EHF12A** \_\_\_\_\_

b) In this job, what were your usual activities or duties?  
Job Duties: **EHF12B** \_\_\_\_\_

c) What was your business or industry? (If necessary: what did they make or do in this business?)  
Business: **EHF12C** \_\_\_\_\_

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d) Did this job expose you to vapors, gas, dust or fumes?..... 

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**EHF12D**  
Yes..... Y  
No ..... N  
Don't know ..... U

e) What year did you begin working in this job?..... 

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**EHF12E**

f) How many years, altogether, did you work in this job? ..... 

--	--

**EHF12F**

g) On average, how many hours per week did you work in this job?..... 

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**EHF12G**

*If Question 2 = 1, 2, or 3 (that is, currently employed) answer questions 13-17)*

13) At this job, what kind of work do you do? That is, what is your occupation?

Occupation: **EHF13** \_\_\_\_\_

14) In this job, what are your usual activities or duties?

Job Duties: **EHF14** \_\_\_\_\_

15) What is your business or industry? (If necessary: what do they make or do in this business?)

Business: **EHF15** \_\_\_\_\_

16) How many years, altogether, have you worked in this job? ..... 

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**EHF16**

17) On average, how many hours per week do you work? ..... 

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**EHF17**

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18) Have you ever worked:

	Yes	No	How many years?
a) in a cotton, flax or hemp mill? .....	<input type="checkbox"/> EHF18A	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18A1
b) in a foundry? .....	<input type="checkbox"/> EHF18B	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18B1
c) in a glass works? .....	<input type="checkbox"/> EHF18C	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18C1
d) in a mine? .....	<input type="checkbox"/> EHF18D	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18D1
e) in a pottery? .....	<input type="checkbox"/> EHF18E	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18E1
f) in a power plant? .....	<input type="checkbox"/> EHF18F	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18F1
g) in a quarry? .....	<input type="checkbox"/> EHF18G	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18G1
h) in a refinery? .....	<input type="checkbox"/> EHF18H	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18H1
i) or with asbestos? .....	<input type="checkbox"/> EHF18I	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18I1
j) in synthetic fibers or fabric manufacturing? .....	<input type="checkbox"/> EHF18J	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18J1
k) in a paper mill? .....	<input type="checkbox"/> EHF18K	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18K1
l) in building or highway construction? .....	<input type="checkbox"/> EHF18L	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18L1
m) in an aluminum factory? .....	<input type="checkbox"/> EHF18M	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18M1
n) in a rubber tire plant? .....	<input type="checkbox"/> EHF18N	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18N1
o) in HVAC? .....	<input type="checkbox"/> EHF18O	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18O1
p) in demolition? .....	<input type="checkbox"/> EHF18P	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18P1
q) in remodeling? .....	<input type="checkbox"/> EHF18Q	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18Q1
r) in professional cleaning? .....	<input type="checkbox"/> EHF18R	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18R1
s) in beauty care? .....	<input type="checkbox"/> EHF18S	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18S1
t) in agriculture? .....	<input type="checkbox"/> EHF18T	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18T1
u) in the flooring industry? .....	<input type="checkbox"/> EHF18U	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF18U1

19) Have you ever worked as:

	Yes	No	How many years?
a) a boilermaker? .....	<input type="checkbox"/> EHF19A	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19A1
b) a carpenter? .....	<input type="checkbox"/> EHF19B	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19B1
c) a chemical worker? .....	<input type="checkbox"/> EHF19C	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19C1
d) an electrician? .....	<input type="checkbox"/> EHF19D	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19D1
e) an elevator operator? .....	<input type="checkbox"/> EHF19E	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19E1
f) an insulator? .....	<input type="checkbox"/> EHF19F	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19F1
g) a lather? .....	<input type="checkbox"/> EHF19G	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19G1
h) a machinist? .....	<input type="checkbox"/> EHF19H	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19H1
i) a mechanic? .....	<input type="checkbox"/> EHF19I	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19I1
j) a millwright? .....	<input type="checkbox"/> EHF19J	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19J1
k) a pipefitter? .....	<input type="checkbox"/> EHF19K	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19K1
l) a plasterer? .....	<input type="checkbox"/> EHF19L	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19L1
m) a plumber? .....	<input type="checkbox"/> EHF19M	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19M1
n) a sander? .....	<input type="checkbox"/> EHF19N	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <input type="checkbox"/> EHF19N1

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- |                                | Yes                             | No                       | How many years?  |
|--------------------------------|---------------------------------|--------------------------|--|
| o) a sheet metal worker? ..... | <input type="checkbox"/> EHF19O | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19O1 |
| p) a steelworker? .....        | <input type="checkbox"/> EHF19P | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19P1 |
| q) a welder? .....             | <input type="checkbox"/> EHF19Q | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19Q1 |
| r) a pig farmer? .....         | <input type="checkbox"/> EHF19R | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19R1 |
| s) a rigger? .....             | <input type="checkbox"/> EHF19S | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19S1 |
| t) a roofer? .....             | <input type="checkbox"/> EHF19T | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19T1 |
| u) a painter? .....            | <input type="checkbox"/> EHF19U | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19U1 |
| v) a mason? .....              | <input type="checkbox"/> EHF19V | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF19V1 |

20) In your job, do/did you come into regular contact with any of the following specific examples of vapors, gas, dust or fumes?

- |  | Yes                             | No                       | How many years?  |
|--|---------------------------------|--------------------------|--|
| a) Irritant gases, such as chlorine or ammonia .....         | <input type="checkbox"/> EHF20A | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20A1 |
| b) Fire, smoke or other combustion products .....            | <input type="checkbox"/> EHF20B | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20B1 |
| c) Incinerators, boilers, or oil refineries .....            | <input type="checkbox"/> EHF20C | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20C1 |
| d) Coal dust or powder .....                                 | <input type="checkbox"/> EHF20D | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20D1 |
| e) Silica or sand, or concrete, cement, or rock dust .....   | <input type="checkbox"/> EHF20E | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20E1 |
| f) Indoor fuel powered motors, compressors, or engines ..... | <input type="checkbox"/> EHF20F | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20F1 |
| g) Diesel engine exhaust .....                               | <input type="checkbox"/> EHF20G | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20G1 |
| h) Wheat flour or other grain dusts .....                    | <input type="checkbox"/> EHF20H | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20H1 |
| i) Animal feeds or fodder .....                              | <input type="checkbox"/> EHF20I | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20I1 |
| j) Cotton dust or cotton processing .....                    | <input type="checkbox"/> EHF20J | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20J1 |
| k) Wood dust or saw dust .....                               | <input type="checkbox"/> EHF20K | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20K1 |
| l) Cadmium fumes or batteries or silver solder .....         | <input type="checkbox"/> EHF20L | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20L1 |
| m) Other metal dusts or metal fumes .....                    | <input type="checkbox"/> EHF20M | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20M1 |
| n) Welding or flame cutting .....                            | <input type="checkbox"/> EHF20N | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20N1 |
| o) Fiberglass or other man-made mineral fibers .....         | <input type="checkbox"/> EHF20O | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20O1 |
| p) Explosives or blasting fumes .....                        | <input type="checkbox"/> EHF20P | <input type="checkbox"/> | <input type="text"/> . <input type="text"/> <input type="text"/> EHF20P1 |

If Question 18d = Y (that is, history of working in a mine) answer questions 21-22)

In question 18 you indicated you have worked in a mine.

- 21) What type of mine was it? .....  EHF21
- Open pit ..... 1
- Underground ..... 2
- Other ..... 3
- Specify:  EHF21A \_\_\_\_\_

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22) What was mined?.....  EHF22

- Hard rock (e.g., lead, zinc, silver, gold, etc)..... 1
- Uranium ..... 2
- Coal ..... 3
- Other ..... 4
- Specify:  EHF22A \_\_\_\_\_

If Question 2 = 1, 2, or 3 (that is, currently employed) answer question 23)

**The following questions relate either to your current job or your longest held job.**

23) Does your current job expose you to vapors, gas, dust or fumes?.....  EHF23

- Yes..... Y
- No ..... N
- Don't know ..... U

24) Is your current work the longest job that you have ever held? .....  EHF24

- Yes..... Y →  End
- No ..... N
- Don't know ..... U →  End

a) In your longest held job, what kind of work did you do? That is, what was your occupation?

Occupation:  EHF24A \_\_\_\_\_

b) In this job, what were your usual activities or duties?

Job Duties:  EHF24B \_\_\_\_\_

c) What was your business or industry? (If necessary: what did they make or do in this business?)

Business:  EHF24C \_\_\_\_\_

d) Did this job expose you to vapors, gas, dust or fumes?.....  EHF24D

- Yes..... Y
- No ..... N
- Don't know ..... U

e) What year did you begin working in this job?.....     EHF24E

f) How many years, altogether, did you work in this job? .....    EHF24F

g) On average, how many hours per week did you work in this job?.....    EHF24G



# EMPLOYMENT HISTORY FORM

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0a) Form Date .....   /   /      **EHF0A**      0b) Staff Code ....

**Instructions:** This form should be completed during the participant's visit. Carefully answer each question regarding current and past employment. For check box questions please select "Yes" or "No" on all items. Please answer all questions.

**The following questions concern employment.**

1) Have you ever been employed for a wage or salary, either part-time or full-time? .....  **EHF01**  
 Yes..... Y  
 No ..... N → **Go to Item 18**  
 No Answer ..... U → **Go to Item 18**

2) Which of the following best describes your current employment situation? .....  **EHF02**  
 Are you currently:  
 Working..... 1 → **Go to Item 13**  
 On leave but still employed ..... 2 → **Go to Item 13**  
 Temporarily laid off..... 3 → **Go to Item 13**  
 Unemployed and looking for work ..... 4  
 Unable to work ..... 5  
 Going to school ..... 6  
 Keeping house ..... 7  
 Retired ..... 8  
 Other ..... 9  
 No answer..... 0 → **Go to Item 18**

3) In your last job, what kind of work did you do? That is, what was your occupation?  
 Occupation : **EHF3** \_\_\_\_\_

4) In this job, what were your usual activities or duties?  
 Job Duties: **EHF04** \_\_\_\_\_

5) What was your business or industry? (If necessary: what did they make or do in this business?)  
 Business: **EHF05** \_\_\_\_\_

6) What year did you begin working in this job? .....     **EHF06**

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7) How many years, altogether, did you work in this job? .....   **EHF07**

7a) On average, how many hours per week did you work in this job? .....   **EHF07A**

8) Did you leave your last job because of breathing or lung problems? .....  **EHF08**

- Yes..... Y
- No ..... N
- No Answer/Don't know ..... U

9) Are you not working at least in part to avoid the things that caused you difficulty breathing, such as air quality, temperature, or physical exertion? .....  **EHF09**

- Yes..... Y
- No ..... N
- Don't know ..... U

10) Thinking back to when you were last employed, did you stop working, at least in part, because of missed time due to illness? .....  **EHF10**

- Yes..... Y
- No ..... N
- Don't know ..... U

11) Did this job expose you to vapors, gas, dust or fumes? .....  **EHF11**

- Yes..... Y
- No ..... N
- Don't know ..... U

12) Was this work the longest job that you have ever held? .....  **EHF12**

- Yes..... Y → **Go to Item 18**
- No ..... N
- Don't know ..... U → **Go to Item 18**

a) In your longest held job, what kind of work did you do? That is, what was your occupation?  
Occupation: **EHF12A** \_\_\_\_\_

b) In this job, what were your usual activities or duties?  
Job Duties: **EHF12B** \_\_\_\_\_

c) What was your business or industry? (If necessary: what did they make or do in this business?)  
Business: **EHF12C** \_\_\_\_\_

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d) Did this job expose you to vapors, gas, dust or fumes?..... 

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**EHF12D**  
Yes.....Y  
No.....N  
Don't know.....U

e) What year did you begin working in this job?..... 

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**EHF12E**

f) How many years, altogether, did you work in this job? ..... 

--	--

**EHF12F**

g) On average, how many hours per week did you work in this job? ..... 

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**EHF12G**

*If Question 2 = 1, 2, or 3 (that is, currently employed) answer questions 13-17)*

13) At this job, what kind of work do you do? That is, what is your occupation?  
Occupation: **EHF13** \_\_\_\_\_

14) In this job, what are your usual activities or duties?  
Job Duties: **EHF14** \_\_\_\_\_

15) What is your business or industry? (If necessary: what do they make or do in this business?)  
Business: **EHF15** \_\_\_\_\_

16) How many years, altogether, have you worked in this job?..... 

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**EHF16**

17) On average, how many hours per week do you work? ..... 

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**EHF17**



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18) Have you ever worked:

	Yes	No	How many years?
a) in a cotton, flax or hemp mill? .....	<input type="checkbox"/> <b>EHF18A</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18A1</b>
b) in a foundry? .....	<input type="checkbox"/> <b>EHF18B</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18B1</b>
c) in a glass works? .....	<input type="checkbox"/> <b>EHF18C</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18C1</b>
d) in a mine? .....	<input type="checkbox"/> <b>EHF18D</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18D1</b>
e) in a pottery? .....	<input type="checkbox"/> <b>EHF18E</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18E1</b>
f) in a power plant? .....	<input type="checkbox"/> <b>EHF18F</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18F1</b>
g) in a quarry? .....	<input type="checkbox"/> <b>EHF18G</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18G1</b>
h) in a refinery? .....	<input type="checkbox"/> <b>EHF18H</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18H1</b>
i) or with asbestos? .....	<input type="checkbox"/> <b>EHF18I</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18I1</b>
j) in synthetic fibers or fabric manufacturing? .....	<input type="checkbox"/> <b>EHF18J</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18J1</b>
k) in a paper mill? .....	<input type="checkbox"/> <b>EHF18K</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18K1</b>
l) in building or highway construction? .....	<input type="checkbox"/> <b>EHF18L</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18L1</b>
m) in an aluminum factory? .....	<input type="checkbox"/> <b>EHF18M</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18M1</b>
n) in a rubber tire plant? .....	<input type="checkbox"/> <b>EHF18N</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18N1</b>
o) in HVAC? .....	<input type="checkbox"/> <b>EHF18O</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18O1</b>
p) in demolition? .....	<input type="checkbox"/> <b>EHF18P</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18P1</b>
q) in remodeling? .....	<input type="checkbox"/> <b>EHF18Q</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18Q1</b>
r) in professional cleaning? .....	<input type="checkbox"/> <b>EHF18R</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18R1</b>
s) in beauty care? .....	<input type="checkbox"/> <b>EHF18S</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18S1</b>
t) in agriculture? .....	<input type="checkbox"/> <b>EHF18T</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18T1</b>
u) in the flooring industry? .....	<input type="checkbox"/> <b>EHF18U</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF18U1</b>

19) Have you ever worked as:

	Yes	No	How many years?
a) a boilermaker? .....	<input type="checkbox"/> <b>EHF19A</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19A1</b>
b) a carpenter? .....	<input type="checkbox"/> <b>EHF19B</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19B1</b>
c) a chemical worker? .....	<input type="checkbox"/> <b>EHF19C</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19C1</b>
d) an electrician? .....	<input type="checkbox"/> <b>EHF19D</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19D1</b>
e) an elevator operator? .....	<input type="checkbox"/> <b>EHF19E</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19E1</b>
f) an insulator? .....	<input type="checkbox"/> <b>EHF19F</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19F1</b>
g) a lather? .....	<input type="checkbox"/> <b>EHF19G</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19G1</b>
h) a machinist? .....	<input type="checkbox"/> <b>EHF19H</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19H1</b>
i) a mechanic? .....	<input type="checkbox"/> <b>EHF19I</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19I1</b>
j) a millwright? .....	<input type="checkbox"/> <b>EHF19J</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19J1</b>
k) a pipefitter? .....	<input type="checkbox"/> <b>EHF19K</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19K1</b>
l) a plasterer? .....	<input type="checkbox"/> <b>EHF19L</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19L1</b>
m) a plumber? .....	<input type="checkbox"/> <b>EHF19M</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19M1</b>
n) a sander? .....	<input type="checkbox"/> <b>EHF19N</b>	<input type="checkbox"/>	<input type="text"/> . <input type="text"/> <b>EHF19N1</b>

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- |                                | Yes                             | No                       | How many years?  |  |  |  |
|--------------------------------|---------------------------------|--------------------------|--|--|--|--|
| o) a sheet metal worker? ..... | <input type="checkbox"/> EHF19O | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19O1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| p) a steelworker? .....        | <input type="checkbox"/> EHF19P | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19P1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| q) a welder? .....             | <input type="checkbox"/> EHF19Q | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19Q1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| r) a pig farmer? .....         | <input type="checkbox"/> EHF19R | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19R1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| s) a rigger? .....             | <input type="checkbox"/> EHF19S | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19S1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| t) a roofer? .....             | <input type="checkbox"/> EHF19T | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19T1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| u) a painter? .....            | <input type="checkbox"/> EHF19U | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19U1 |  |  |  |
|                                |                                 |                          |  |  |  |  |
| v) a mason? .....              | <input type="checkbox"/> EHF19V | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF19V1 |  |  |  |
|                                |                                 |                          |  |  |  |  |

20) In your job, do/did you come into regular contact with any of the following specific examples of vapors, gas, dust or fumes?

- |   | Yes                             | No                       | How many years?  |  |  |  |
|---|---------------------------------|--------------------------|--|--|--|--|
| a) Irritant gases, such as chlorine or ammonia.....     | <input type="checkbox"/> EHF20A | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20A1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| b) Fire, smoke or other combustion products .....       | <input type="checkbox"/> EHF20B | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20B1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| c) Incinerators, boilers, or oil refineries .....       | <input type="checkbox"/> EHF20C | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20C1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| d) Coal dust or powder.....                             | <input type="checkbox"/> EHF20D | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20D1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| e) Silica or sand, or concrete, cement, or rock dust .. | <input type="checkbox"/> EHF20E | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20E1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| f) Indoor fuel powered motors, compressors, or engines. | <input type="checkbox"/> EHF20F | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20F1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| g) Diesel engine exhaust .....                          | <input type="checkbox"/> EHF20G | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20G1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| h) Wheat flour or other grain dusts.....                | <input type="checkbox"/> EHF20H | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20H1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| i) Animal feeds or fodder.....                          | <input type="checkbox"/> EHF20I | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20I1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| j) Cotton dust or cotton processing .....               | <input type="checkbox"/> EHF20J | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20J1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| k) Wood dust or saw dust .....                          | <input type="checkbox"/> EHF20K | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20K1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| l) Cadmium fumes or batteries or silver solder .....    | <input type="checkbox"/> EHF20L | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20L1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| m) Other metal dusts or metal fumes .....               | <input type="checkbox"/> EHF20M | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20M1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| n) Welding or flame cutting .....                       | <input type="checkbox"/> EHF20N | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20N1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| o) Fiberglass or other man-made mineral fibers.....     | <input type="checkbox"/> EHF20O | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20O1 |  |  |  |
|   |                                 |                          |  |  |  |  |
| p) Explosives or blasting fumes .....                   | <input type="checkbox"/> EHF20P | <input type="checkbox"/> | <table border="1"><tr><td></td><td></td><td></td></tr></table> EHF20P1 |  |  |  |
|   |                                 |                          |  |  |  |  |

If Question 18d = Y (that is, history of working in a mine) answer questions 23-24)

In question 18 you indicated you have worked in a mine.

- 21) What type of mine was it? 

--

 EHF21
- Open pit ..... 1
- Underground..... 2
- Other ..... 3
- Specify: 

EHF21A
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- 22) What was mined?.....  EHF22
- Hard rock (e.g., lead, zinc, silver, gold, etc) ..... 1
  - Uranium ..... 2
  - Coal ..... 3
  - Other ..... 4
- Specify: EHF22A \_\_\_\_\_

If Question 2 = 1, 2, or 3 (that is, currently employed) answer question 23)

**The following questions relate either to your current job or your longest held job.**

- 23) Does your current job expose you to vapors, gas, dust or fumes?.....  EHF23
- Yes..... Y
  - No ..... N
  - Don't know ..... U

- 24) Is your current work the longest job that you have ever held? .....  EHF24
- Yes..... Y → End
  - No ..... N
  - Don't know ..... U → End

a) In your longest held job, what kind of work did you do? That is, what was your occupation?  
Occupation: EHF24A \_\_\_\_\_

b) In this job, what were your usual activities or duties?  
Job Duties: EHF24B \_\_\_\_\_

c) What was your business or industry? (If necessary: what did they make or do in this business?)  
Business: EHF24C \_\_\_\_\_

- d) Did this job expose you to vapors, gas, dust or fumes?.....  EHF24D
- Yes..... Y
  - No ..... N
  - Don't know ..... U

e) What year did you begin working in this job?.....    EHF24E

f) How many years, altogether, did you work in this job? .....   EHF24F

g) On average, how many hours per week did you work in this job? .....   EHF24G



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7) How many years, altogether, did you work in this job? .....   **EHF07**

8) Did you leave your last job because of breathing or lung problems? .....  **EHF08**  
Yes.....Y  
No.....N  
No Answer/Don't know.....U

9) Are you not working at least in part to avoid the things that caused you difficulty breathing, such as air quality, temperature, or physical exertion? .....  **EHF09**  
Yes.....Y  
No.....N  
Don't know.....U

10) Thinking back to when you were last employed, did you stop working, at least in part, because of missed time due to illness? .....  **EHF10**  
Yes.....Y  
No.....N  
Don't know.....U

11) Did this job expose you to vapors, gas, dust or fumes?.....  **EHF11**  
Yes.....Y  
No.....N  
Don't know.....U

12) Was this work the longest job that you have ever held? .....  **EHF12**  
Yes.....Y → **Go to Item 18**  
No.....N  
Don't know.....U → **Go to Item 18**

a) In your longest held job, what kind of work did you do? That is, what was your occupation?  
Occupation: **EHF12A** \_\_\_\_\_

b) In this job, what were your usual activities or duties?  
Job Duties: **EHF12B** \_\_\_\_\_

c) What was your business or industry? (If necessary: what did they make or do in this business?)  
Business: **EHF12C** \_\_\_\_\_

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- d) Did this job expose you to vapors, gas, dust or fumes? .....  **EHF12D**  
Yes.....Y  
No .....N  
Don't know .....U

If Question 2 = 1, 2, or 3 (that is, currently employed) answer questions 13-17)

13) At this job, what kind of work do you do? That is, what is your occupation?

Occupation: **EHF13** \_\_\_\_\_

14) In this job, what are your usual activities or duties?

Job Duties: **EHF14** \_\_\_\_\_

15) What is your business or industry? (If necessary: what do they make or do in this business?)

Business: **EHF15** \_\_\_\_\_

16) How many years, altogether, have you worked in this job? .....   **EHF16**

17) On average, how many hours per week do you work? .....   **EHF17**

18) Have you ever worked:

- |   | Yes                      |
|---|--------------------------|
| a) in a cotton, flax or hemp mill? .....              | <input type="checkbox"/> |
| b) in a foundry? .....                                | <input type="checkbox"/> |
| c) in a glass works? .....                            | <input type="checkbox"/> |
| d) in a mine? .....                                   | <input type="checkbox"/> |
| e) in a pottery? .....                                | <input type="checkbox"/> |
| f) in a power plant? .....                            | <input type="checkbox"/> |
| g) in a quarry? .....                                 | <input type="checkbox"/> |
| h) in a refinery? .....                               | <input type="checkbox"/> |
| i) or with asbestos? .....                            | <input type="checkbox"/> |
| j) in synthetic fibers or fabric manufacturing? ..... | <input type="checkbox"/> |
| k) in a paper mill? .....                             | <input type="checkbox"/> |
| l) in building or highway construction? .....         | <input type="checkbox"/> |
| m) in an aluminum factory? .....                      | <input type="checkbox"/> |
| n) in a rubber tire plant? .....                      | <input type="checkbox"/> |
| o) in HVAC? .....                                     | <input type="checkbox"/> |

No

- |                          |               |
|--------------------------|---------------|
| <input type="checkbox"/> | <b>EHF18A</b> |
| <input type="checkbox"/> | <b>EHF18B</b> |
| <input type="checkbox"/> | <b>EHF18C</b> |
| <input type="checkbox"/> | <b>EHF18D</b> |
| <input type="checkbox"/> | <b>EHF18E</b> |
| <input type="checkbox"/> | <b>EHF18F</b> |
| <input type="checkbox"/> | <b>EHF18G</b> |
| <input type="checkbox"/> | <b>EHF18H</b> |
| <input type="checkbox"/> | <b>EHF18I</b> |
| <input type="checkbox"/> | <b>EHF18J</b> |
| <input type="checkbox"/> | <b>EHF18K</b> |
| <input type="checkbox"/> | <b>EHF18L</b> |
| <input type="checkbox"/> | <b>EHF18M</b> |
| <input type="checkbox"/> | <b>EHF18N</b> |
| <input type="checkbox"/> | <b>EHF18O</b> |

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- Yes
- p) in demolition? .....
  - q) in remodeling? .....
  - r) in professional cleaning? .....
  - s) in beauty care? .....
  - t) in agriculture? .....
  - u) in the flooring industry? .....

- No
- EHF18P
  - EHF18Q
  - EHF18R
  - EHF18S
  - EHF18T
  - EHF18U

- 19) Have you ever worked as:
- Yes
- a) a boilermaker? .....
  - b) a carpenter? .....
  - c) a chemical worker? .....
  - d) an electrician? .....
  - e) an elevator operator? .....
  - f) an insulator? .....
  - g) a lather? .....
  - h) a machinist? .....
  - i) a mechanic? .....
  - j) a millwright? .....
  - k) a pipefitter? .....
  - l) a plasterer? .....
  - m) a plumber? .....
  - n) a sander? .....
  - o) a sheet metal worker? .....
  - p) a steelworker? .....
  - q) a welder? .....
  - r) a pig farmer? .....
  - s) a rigger? .....
  - t) a roofer? .....
  - u) a painter? .....
  - v) a mason? .....

- No
- EHF19A
  - EHF19B
  - EHF19C
  - EHF19D
  - EHF19E
  - EHF19F
  - EHF19G
  - EHF19H
  - EHF19I
  - EHF19J
  - EHF19K
  - EHF19L
  - EHF19M
  - EHF19N
  - EHF19O
  - EHF19P
  - EHF19Q
  - EHF19R
  - EHF19S
  - EHF19T
  - EHF19U
  - EHF19V

20) In your job, do/did you come into regular contact with any of the following specific examples of vapors, gas, dust or fumes?

- Yes
- a) Irritant gases, such as chlorine or ammonia .....
  - b) Fire, smoke or other combustion products .....
  - c) Incinerators, boilers, or oil refineries .....
  - d) Coal dust or powder .....
  - e) Silica or sand, or concrete or cement dust .....
  - f) Indoor fuel powered motors, compressors, or engines .....

- No
- EHF20A
  - EHF20B
  - EHF20C
  - EHF20D
  - EHF20E
  - EHF20F

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- |  | <u>Yes</u>               | <u>No</u>                       |
|--|--------------------------|---------------------------------|
| g) Diesel engine exhaust .....                       | <input type="checkbox"/> | <input type="checkbox"/> EHF20G |
| h) Wheat flour or other grain dusts.....             | <input type="checkbox"/> | <input type="checkbox"/> EHF20H |
| i) Animal feeds or fodder.....                       | <input type="checkbox"/> | <input type="checkbox"/> EHF20I |
| j) Cotton dust or cotton processing .....            | <input type="checkbox"/> | <input type="checkbox"/> EHF20J |
| k) Wood dust or saw dust .....                       | <input type="checkbox"/> | <input type="checkbox"/> EHF20K |
| l) Cadmium fumes or batteries or sliver solder ..... | <input type="checkbox"/> | <input type="checkbox"/> EHF20L |
| m) Other metal dusts or metal fumes .....            | <input type="checkbox"/> | <input type="checkbox"/> EHF20M |
| n) Welding or flame cutting .....                    | <input type="checkbox"/> | <input type="checkbox"/> EHF20N |
| o) Fiberglass or other man-made mineral fibers.....  | <input type="checkbox"/> | <input type="checkbox"/> EHF20O |
| p) Explosives or blasting fumes .....                | <input type="checkbox"/> | <input type="checkbox"/> EHF20P |





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- 4. Was the participant prescribed new antibiotics for this respiratory event? .....  **ERF4**  
    Yes ..... 1  
    No/NR..... 0
- 5. Was the participant prescribed new steroids for this respiratory event?.....  **ERF5**  
    Yes ..... 1  
    No/NR..... 0
- 6. Did the subject have radiographic evidence suggestive of pneumonia? .....  **ERF6**  
    Yes ..... 1  
    No/NR..... 0
- 7. Did the participant have acute respiratory failure with no known cause? .....  **ERF7**  
    Yes ..... 1  
    No/NR..... 0

**PART C: Classification of Event**

8. Did the participant have a COPD exacerbation? ..... [display chain message] **ERF8**

*(Click to run exacerbation eligibility)*

9. Do you agree with the symptomatic classification? .....  **ERF9**  
    Yes ..... 1  
    No ..... 0

10. If no, provide reason and cite any relevant case law

**ERF10**

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11. Was this event a death? .....  **ERF11**  
    Yes ..... 1  
    No ..... 0 → **Skip to Q19**

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12. What was the primary cause of death? (enter one cause here, then proceed to the question indicated)...
- a. Respiratory ..... 1 → Skip to Q13 ERF12
  - b. Cardiovascular ..... 2 → Skip to Q14
  - c. Cancer ..... 3 → Skip to Q15
  - d. Other, Known ..... 4 → Skip to Q16
  - e. Unknown.....5 → Skip to Q17

13. Respiratory (select only one) .....  ERF13
- COPD Exacerbation with pneumonia ..... 1
  - COPD Exacerbation without pneumonia..... 2
  - COPD without exacerbation..... 3
  - Other respiratory ..... 4
- 13a. Specify: ERF13A \_\_\_\_\_

14. Cardiovascular (select only one) .....  ERF14
- Myocardial infarction..... 1
  - Heart failure.....2
  - Stroke/aneurysm.....3
  - DVT/PE.....4
  - Other heart problem .....5
- 14a. Specify: ERF14A \_\_\_\_\_

- 14b. Type of Cardiovascular death (select only one).....  ERF14B
- 14b1. "Sudden Death," defined as death that occurs within 24 hours of being observed alive and without evidence of a deteriorating medical condition)..... 1
  - 14b2. "Sudden Cardiac Death," defined as death that occurs within 1 hour of being observed alive and without evidence of a deteriorating medical condition..... 2
  - 14b3. Neither of the above..... 3

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15. Cancer (select only one).....  **ERF15**

Lung..... 1

Other cancer..... 2

15a. Specify: **ERF15A** \_\_\_\_\_

16. Other, Known

Specify: **ERF16** \_\_\_\_\_

17. Reason for Unknown cause of death (select only one) .....  **ERF17**

Information is inadequate..... 1

Indeterminate (information available but cause unclear)..... 2

Please answer for any type of death:

18. Do you believe that a diagnosis of COPD contributed to the death of this individual?.....  **ERF18**

Yes ..... 1

No ..... 2

19. Should this case be reviewed by the Committee? .....  **ERF19**

Yes ..... 1

No ..... 2

**Note: Question 19 must be answered for the form to be considered complete**

Comments:

**ERF19A** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ **End form**



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8	ETF8A / /	ETF8C	ETF8D	ETF8B
9	ETF9A / /	ETF9C	ETF9D	ETF9B
10	ETF10A / /	ETF10C	ETF10D	ETF10B
11	ETF11A / /	ETF11C	ETF11D	ETF11B
12	ETF12A / /	ETF12C	ETF12D	ETF12B
13	ETF13A / /	ETF13C	ETF13D	ETF13B
14	ETF14A / /	ETF14C	ETF14D	ETF14B
15	ETF15A / /	ETF15C	ETF15D	ETF15B
16	ETF16A / /	ETF16C	ETF16D	ETF16B
17	ETF17A / /	ETF17C	ETF17D	ETF17B
18	ETF18A / /	ETF18C	ETF18D	ETF18B
19	ETF19A / /	ETF19C	ETF19D	ETF19B
20	ETF20A / /	ETF20C	ETF20D	ETF20B
21	ETF21A / /	ETF21C	ETF21D	ETF21B
22	ETF22A / /	ETF22C	ETF22D	ETF22B
23	ETF23A / /	ETF23C	ETF23D	ETF23B
24	ETF24A / /	ETF24C	ETF24D	ETF24B

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Please indicate whether any of the following ICD9 codes are listed on the Discharge Summary, Admission and Physical History, and/or Visit Summary:

25a. Were ICD9 Codes used? (Y/N)  ETF25A

Diagnoses	ICD9	Diagnoses	ICD9
Acute upper respiratory infection	465.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B1	Pulmonary congestion and hypostasis (includes pulmonary edema NOS chronic)	514.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B2
Acute bronchitis	466.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B3	Other diseases of lung	518.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B4
Viral Pneumonia	480.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B5	Heart Failure	428.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B6
Pneumococcal pneumonia	481.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B7	Lung cancer	162.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B8
Other bacterial pneumonia	482.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B9	Lung cancer	163.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B10
Pneumonia due to other specified organism	483.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B11	Diabetes	249.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B12
Bronchopneumonia, organism unspecified	485.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B13	Diabetes	250.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B14
Pneumonia, organism unspecified	486.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B15	Other venous embolism and thrombosis Venous thrombosis (DVT)	453.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B16
Influenza	487.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B17	Acute pulmonary heart disease	415.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B18
Influenza due to certain identified influenza viruses	488.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B19	Pulmonary embolus	415.1 <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B20
Bronchitis	490.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B21	Osteoporosis	733.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B22
Chronic bronchitis	491.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B23	Hip Fracture	820.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B24
Emphysema	492.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B25	Hip Fracture	821.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B26
Asthma	493.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B27	Acute Myocardial Infarction	410.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B28
Bronchiectasis	494.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B29	Other acute and sub-acute forms of ischemic heart disease Myocardial Infarction	411.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B30
COPD	496.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B31	Other forms of chronic ischemic heart disease Myocardial Infarction	414.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B32
Pneumonitis due to solids and liquids	507.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B33	Occlusion and stenosis of pre-cerebral arteries	433.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B34
Empyema	510.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B35	Occlusion of cerebral arteries Stroke or transient ischemic attack	434.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B36
Pleurisy	511.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B37	Transient cerebral ischemia	435.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B38
Pneumothorax and air leak	512.X <input checked="" type="checkbox"/> <input type="checkbox"/> ETF25B39	Abscess of lung and mediastinum	513.X <input type="checkbox"/> <input checked="" type="checkbox"/> ETF25B40

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Please indicate whether any of the following ICD10 codes are listed on the Discharge Summary, Admission and Physical History, and/or Visit Summary:

26a. Were ICD10 Codes used? (Y/N) **ETF26A**

Diagnoses	ICD10	Diagnoses	ICD10
Acute upper respiratory infections of multiple and unspecified sites	J06.X <input checked="" type="checkbox"/> <b>ETF26B1</b>	Pleural effusion, not elsewhere classified	J90.X <b>ETF26B2</b>
Influenza due to identified novel influenza A virus	J09.X <input type="checkbox"/> <b>ETF26B3</b>	Pleural effusion in conditions classified elsewhere	J91.X <b>ETF26B4</b>
Influenza due to other identified influenza virus	J10.X <input type="checkbox"/> <b>ETF26B5</b>	Pneumothorax and air leak	J93.X <b>ETF26B6</b>
Influenza, due to unidentified influenza virus	J11.X <input checked="" type="checkbox"/> <b>ETF26B7</b>	Other pleural conditions	J94.X <b>ETF26B8</b>
Viral pneumonia, not elsewhere classified	J12.X <input checked="" type="checkbox"/> <b>ETF26B9</b>	Intraoperative and post-procedural complications and disorders of respiratory system, not elsewhere classified	J95.X <b>ETF26B10</b>
Pneumonia due to Streptococcus pneumonia	J13.X <input type="checkbox"/> <b>ETF26B11</b>	Respiratory failure, not elsewhere classified	J96.X <b>ETF26B12</b>
Pneumonia due to Haemophilus influenzae	J14.X <input type="checkbox"/> <b>ETF26B13</b>	Other respiratory disorders	J98.X <b>ETF26B14</b>
Bacterial pneumonia, not elsewhere classified	J15.X <input type="checkbox"/> <b>ETF26B15</b>	Heart Failure	I50.X <b>ETF26B16</b>
Pneumonia due to other infectious organisms, not elsewhere classified	J16.X <input type="checkbox"/> <b>ETF26B17</b>	Malignant neoplasm of trachea	C33.X <b>ETF26B18</b>
Pneumonia in diseases classified elsewhere	J17.X <input type="checkbox"/> <b>ETF26B19</b>	Malignant neoplasm of bronchus and lung	C34.X <b>ETF26B20</b>
Pneumonia, unspecified organism	J18.X <input checked="" type="checkbox"/> <b>ETF26B21</b>	Malignant neoplasm of pleura	C38.4 <b>ETF26B22</b>
Acute bronchitis	J20.X <input checked="" type="checkbox"/> <b>ETF26B23</b>	Diabetes mellitus, Type 1	E10.X <b>ETF26B24</b>
Acute bronchiolitis	J21.X <input checked="" type="checkbox"/> <b>ETF26B25</b>	Diabetes mellitus, Type 2	E11.X <b>ETF26B26</b>
Unspecified acute lower respiratory infection	J22.X <input type="checkbox"/> <b>ETF26B27</b>	Phlebitis and thrombophlebitis	I80.X <b>ETF26B28</b>
Bronchitis, not specified as acute or chronic	J40.X <input type="checkbox"/> <b>ETF26B29</b>	Portal vein thrombosis	I81.X <b>ETF26B30</b>
Simple and mucopurulent chronic bronchitis	J41.X <input type="checkbox"/> <b>ETF26B31</b>	Other venous embolism and thrombosis	I82.X <b>ETF26B32</b>
Unspecified chronic bronchitis	J42.X <input type="checkbox"/> <b>ETF26B33</b>	Pulmonary embolism	I26.X <b>ETF26B34</b>
Emphysema	J43.X <input type="checkbox"/> <b>ETF26B35</b>	Osteoporosis with current pathological fracture	M80.X <b>ETF26B36</b>
Other chronic obstructive pulmonary disease	J44.X <input type="checkbox"/> <b>ETF26B37</b>	Osteoporosis without current pathological fracture	M81.X <b>ETF26B38</b>
Asthma	J45.X <input checked="" type="checkbox"/> <b>ETF26B39</b>	Osteoporosis in diseases classified elsewhere	M82.X <b>ETF26B40</b>
Status asthmaticus (acute severe asthma)	J46.X <input checked="" type="checkbox"/> <b>ETF26B41</b>	Fracture of femur	S72.X <b>ETF26B42</b>
Bronchiectasis	J47.X <input checked="" type="checkbox"/> <b>ETF26B43</b>	Angina pectoris	I20.X <b>ETF26B44</b>



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Diagnoses	ICD10	Diagnoses	ICD10
Respiratory conditions due to inhalation of chemicals, gases, fumes and vapors	J68.X <input type="checkbox"/> <b>ETF26B45</b>	ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction	I21.X <b>ETF26B46</b>
Pneumonitis due to solids and liquids	J69.X <input type="checkbox"/> <b>ETF26B47</b>	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction	I22.X <b>ETF26B48</b>
Respiratory conditions due to other external agents	J70.X <input type="checkbox"/> <b>ETF26B49</b>	Certain current complications following ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction (within the 28 day period)	I23.X <b>ETF26B50</b>
Adult respiratory distress syndrome	J80.X <input type="checkbox"/> <b>ETF26B51</b>	Other acute ischemic heart diseases	I24.X <b>ETF26B52</b>
Pulmonary edema	J81.X <input type="checkbox"/> <b>ETF26B53</b>	Cerebral infarction	I63 <b>ETF26B54</b>
Abscess of lung and mediastinum	J85.X <input type="checkbox"/> <b>ETF26B55</b>	Stroke, not specified as hemorrhage or infarction	I64 <b>ETF26B56</b>
Pyothorax	J86.X <input type="checkbox"/> <b>ETF26B57</b>	Transient cerebral ischemic attacks and related syndromes	G45.X <b>ETF26B58</b>
Chronic ischemic heart disease	I25.X <input type="checkbox"/> <b>ETF26B59</b>		

27a. Were additional diagnoses or procedures listed on coding summary requiring full medical records request? (Y/N) **ETF27A**

- Mechanical Ventilation not in the setting of a surgical procedure  **ETF27B1**
- Lung Transplantation  **ETF27B2**
- Report of other respiratory problem treated  **ETF27B3**

ID NUMBER:								
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FORM CODE: ETF  
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28. For each of the items below, please indicate if the record is included in the packet to the GIC:

<b>Medical Record</b>	<b>Status</b>	
ICD-9 or -10 Coding Summary	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28A
Admission History and Physical	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28B
Discharge Summary	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28C
Emergency Department Report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28D
General labs	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28E
Microbiology labs	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28F
Procedure or surgical reports	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28G
Spirometry report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28H
Echo report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28I
RVG or MUGA report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28J
Doppler Flow Study report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28K
Pulse oximetry reports	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28L
Arterial blood gas report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28M
Discharge medication report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28N
Chest X-ray reports	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28O
Chest CT scan reports	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28P
Pulmonary angiography report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28Q
V/Q Lung scan	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28R
Autopsy or Medical examiner report	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28S
Death Certificate	<input type="checkbox"/> Included <input type="checkbox"/> Available, not included <input type="checkbox"/> Unavailable <input type="checkbox"/> Not collected	ETF28T

**EVT – GIC Event Packet Tracking  
V1 20150109**

0a. Event ID:  0b. Event Date:

0c. Last Accessed Date: \_\_\_\_\_ 0d. Staff Code: \_\_\_\_\_

1. Date Packet Received:
2. Initials of check-in processor:
3. Number of pages in the packet:
4. Diagnosis codes used: ICD9/ICD10

3a.	ICD9 Codes	3b.	ICD10 Codes
	<input type="text" value="EVT4A1"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B1"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A2"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B2"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A3"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B3"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A4"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B4"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A5"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B5"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A6"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B6"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A7"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B7"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A8"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B8"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A9"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B9"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A10"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B10"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A11"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B11"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A12"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B12"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A13"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B13"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A14"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B14"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A15"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B15"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A16"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B16"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A17"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B17"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A18"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B18"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A19"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B19"/> . <input type="text"/> . <input type="text"/>
	<input type="text" value="EVT4A20"/> . <input type="text"/> . <input type="text"/>		<input type="text" value="EVT4B20"/> . <input type="text"/> . <input type="text"/>

5. Initial Packet Event Assessment:   
 Eligible Event.....1  
 Ineligible Event.....2
6. Initial Packet Review Status: Packet Complete   
 Complete.....1 (skip 6a)  
 Incomplete.....0 (*specify missing items and rest of form skipped*)

6a. Select missing items that apply

- |                                |  |
|--------------------------------|--|
|                                | Y/N  |
| ICD Coding Summary             | <input type="checkbox"/> <input type="text" value="EVT6A1"/> |
| Admission History and Physical | <input type="checkbox"/> <input type="text" value="EVT6A2"/> |
| Discharge Summary              | <input type="checkbox"/> <input type="text" value="EVT6A3"/> |
| Emergency Department Report    | <input type="checkbox"/> <input type="text" value="EVT6A4"/> |
| General labs                   | <input type="checkbox"/> <input type="text" value="EVT6A5"/> |

- Microbiology labs  EVT6A6
- Procedure or surgical reports  EVT6A7
- Spirometry report  EVT6A8
- Echo report  EVT6A9
- Pulse oximetry reports  EVT6A10
- Arterial blood gas report  EVT6A11
- Discharge medication report  EVT6A12
- Chest X-ray reports  EVT6A13
- Chest CT scan reports  EVT6A14
- Pulmonary angiography report  EVT6A15
- V/Q Lung scan  EVT6A16
- Autopsy or Medical examiner report  EVT6A17
- Death certificate  EVT6A18
- Improperly blinded  EVT6A19
- Improperly labeled  EVT6A20
- Other  EVT6A21

6b) Specify other:

7. Abstractor Packet Review Status:   
 Complete.....1 (skip 7a)  
 Incomplete.....0 (*specify missing items and rest of form skipped*)

7a. Select missing items that apply

- |                                    | Y/N                              |
|------------------------------------|----------------------------------|
| ICD Coding Summary                 | <input type="checkbox"/> EVT7A1  |
| Admission History and Physical     | <input type="checkbox"/> EVT7A2  |
| Discharge Summary                  | <input type="checkbox"/> EVT7A3  |
| Emergency Department Report        | <input type="checkbox"/> EVT7A4  |
| General labs                       | <input type="checkbox"/> EVT7A5  |
| Microbiology labs                  | <input type="checkbox"/> EVT7A6  |
| Procedure or surgical reports      | <input type="checkbox"/> EVT7A7  |
| Spirometry report                  | <input type="checkbox"/> EVT7A8  |
| Echo report                        | <input type="checkbox"/> EVT7A9  |
| Pulse oximetry reports             | <input type="checkbox"/> EVT7A10 |
| Arterial blood gas report          | <input type="checkbox"/> EVT7A11 |
| Discharge medication report        | <input type="checkbox"/> EVT7A12 |
| Chest X-ray reports                | <input type="checkbox"/> EVT7A13 |
| Chest CT scan reports              | <input type="checkbox"/> EVT7A14 |
| Pulmonary angiography report       | <input type="checkbox"/> EVT7A15 |
| V/Q Lung scan                      | <input type="checkbox"/> EVT7A16 |
| Autopsy or Medical examiner report | <input type="checkbox"/> EVT7A17 |
| Death certificate                  | <input type="checkbox"/> EVT7A18 |
| Improperly blinded                 | <input type="checkbox"/> EVT7A19 |
| Improperly labeled                 | <input type="checkbox"/> EVT7A20 |
| Other                              | <input type="checkbox"/> EVT7A21 |

7b) Specify other:

8. Event eligible for abstraction?   
 Yes.....1  
 No.....0

9. Abstraction Status : EVT9  
Complete.....1  
In-progress.....0



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**SOCIAL/FAMILY WELL-BEING**

		Not at all	A little bit	Some -what	Quite a bit	Very much	
8	I feel close to my friends .....	0	1	2	3	4	FCT08
9	I get emotional support from my family .....	0	1	2	3	4	FCT09
10	I get support from my friends .....	0	1	2	3	4	FCT10
11	My family has accepted my illness .....	0	1	2	3	4	FCT11
12	I am satisfied with family communication about my illness.....	0	1	2	3	4	FCT12
13	I feel close to my partner (or the person who is my main support) .....	0	1	2	3	4	FCT13
14	<i>Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box <input type="checkbox"/> and go to the next section.</i>						FCT14
15	I am satisfied with my sex life .....	0	1	2	3	4	FCT15

ID NUMBER:									
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Please indicate your response as it applies to the past 7 days.

**EMOTIONAL WELL-BEING**

		Not at all	A little bit	Some -what	Quite a bit	Very much
16	I feel sad.....	0	1	2	3	4 <b>FCT16</b>
17	I am satisfied with how I am coping with my illness.....	0	1	2	3	4 <b>FCT17</b>
18	I am losing hope in the fight against my illness .....	0	1	2	3	4 <b>FCT18</b>
19	I feel nervous.....	0	1	2	3	4 <b>FCT19</b>
20	I worry about dying.....	0	1	2	3	4 <b>FCT20</b>
21	I worry that my condition will get worse .....	0	1	2	3	4 <b>FCT21</b>

**FUNCTIONAL WELL-BEING**

		Not at all	A little bit	Some -what	Quite a bit	Very much
22	I am able to work (include work at home).....	0	1	2	3	4 <b>FCT22</b>
23	My work (include work at home) is fulfilling .....	0	1	2	3	4 <b>FCT23</b>
24	I am able to enjoy life .....	0	1	2	3	4 <b>FCT24</b>
25	I have accepted my illness.....	0	1	2	3	4 <b>FCT25</b>
26	I am sleeping well .....	0	1	2	3	4 <b>FCT26</b>
27	I am enjoying the things I usually do for fun .....	0	1	2	3	4 <b>FCT27</b>
28	I am content with the quality of my life right now .....	0	1	2	3	4 <b>FCT28</b>



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Please indicate your response as it applies to the past 7 days.

<b><u>ADDITIONAL CONCERNS</u></b>		<b>Not at all</b>	<b>A little bit</b>	<b>Some -what</b>	<b>Quite a bit</b>	<b>Very much</b>	
29	I feel fatigued .....	0	1	2	3	4	FCT29
30	I feel weak all over .....	0	1	2	3	4	FCT30
31	I feel listless ("washed out") .....	0	1	2	3	4	FCT31
32	I feel tired .....	0	1	2	3	4	FCT32
33	I have trouble <u>starting</u> things because I am tired .....	0	1	2	3	4	FCT33
34	I have trouble <u>finishing</u> things because I am tired .....	0	1	2	3	4	FCT34
35	I have energy .....	0	1	2	3	4	FCT35
36	I am able to do my usual activities .....	0	1	2	3	4	FCT36
37	I need to sleep during the day .....	0	1	2	3	4	FCT37
38	I am too tired to eat .....	0	1	2	3	4	FCT38
39	I need help doing my usual activities .....	0	1	2	3	4	FCT39
40	I am frustrated by being too tired to do the things I want to do ..	0	1	2	3	4	FCT40
41	I have to limit my social activity because I am tired .....	0	1	2	3	4	FCT41



ID NUMBER:									
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FORM CODE: **FUQ**  
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### HOSPITALIZATIONS

(If non-COPD participant, skip to question 20)

(For COPD Participants Only):

2) Since your last (*clinic visit or telephone contact*) on (*date*), have you had a flare-up of your chest trouble? (Y/N).....  **FUQ02**  
(if 'No' go to item 20)

If Yes:

2a) How many episodes of chest trouble flare ups have you had since (*date*)? .....  **FUQ02A**

How was/were the episode(s) of breathing problem(s) treated? Please answer for each episode (if more than one) by checking all relevant treatments given for each episode. Starting with the first episode since (*date*):

3) For the first episode of breathing problems you had since (*date*):

3a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ3A**

3b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ3B**

3c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ3C**

3d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **FUQ3D**

3e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ3E**

During that visit were you given (check all that apply):

3e1) An additional antibiotic .....  **FUQ03E1**

3e2) Additional steroids .....  **FUQ03E2**

3e3) Don't know .....  **FUQ03E3**

3e4) Don't remember .....  **FUQ03E4**

3f) Were you evaluated in an Emergency Department? .....  **FUQ03F**

During that visit were you given (check all that apply):

3f1) An additional antibiotic .....  **FUQ03F1**

3f2) Additional steroids .....  **FUQ03F2**

3f3) Don't know .....  **FUQ03F3**

3f4) Don't remember .....  **FUQ03F4**

3g) Were you admitted to the hospital? .....  **FUQ03G**

If participant was admitted to hospital:

4a) What was the date of this event? ..... // **FUQ04A**

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SEQ #

4b) What is the name of the medical facility?  **Removed from Blinded Dataset**

4c) What is the address of this medical facility?  **Removed from Blinded Dataset**  
(Leave blank if unknown)

4d) For clarification of our records, under what name is this record?

4d1) First Name:  **Removed from Blinded Dataset**

4d2) Second Name:  **Removed from Blinded Dataset**

4d3) Last Name:  **Removed from Blinded Dataset**

4d4) Maternal Last Name:  **Removed from Blinded Dataset**

5) (do not ask) Did the participant have a second episode? (if 'No', go to 20) .....  **FUQ05**

6) For the second episode of breathing problems you had since (date):

6a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ06A**

6b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ06B**

6c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ06C**

6d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  **FUQ06D**

6e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ06E**

During that visit were you given (check all that apply):

6e1) An additional antibiotic .....  **FUQ06E1**

6e2) Additional steroids .....  **FUQ06E2**

6e3) Don't know .....  **FUQ06E3**

6e4) Don't remember .....  **FUQ06E4**

6f) Were you evaluated in an Emergency Department? .....  **FUQ06F**

During that visit were you given (check all that apply):

6f1) An additional antibiotic .....  **FUQ06F1**

6f2) Additional steroids .....  **FUQ06F2**

6f3) Don't know .....  **FUQ06F3**

6f4) Don't remember .....  **FUQ06F4**

g) Where you admitted to the hospital  **FUQ06G**  
If participant was admitted to hospital:

7a) What was the date of this event? .....   /   /      **FUQ07A**

ID NUMBER:

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7b) What is the name of the medical facility? Removed from Blinded Dataset

7c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

7d) For clarification of our records, under what name is this record?

7d1) First Name: Removed from Blinded Dataset

7d2) Second Name: Removed from Blinded Dataset

7d3) Last Name: Removed from Blinded Dataset

7d4) Maternal Last Name: Removed from Blinded Dataset

8) (do not ask) Did the participant have a third episode? (if 'No', go to 20) .....  **FUQ08**

9) For the third episode of breathing problems you had since (date):

9a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ09A**

9b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ09B**

9c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ09C**

9d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **FUQ09D**

9e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ09E**

During that visit were you given (check all that apply):

9e1) An additional antibiotic .....  **FUQ09E1**

9e2) Additional steroids .....  **FUQ09E2**

9e3) Don't know .....  **FUQ09E3**

9e4) Don't remember .....  **FUQ09E4**

9f) Were you evaluated in an Emergency Department? .....  **FUQ09F**

During that visit were you given (check all that apply):

9f1) An additional antibiotic .....  **FUQ09F1**

9f2) Additional steroids .....  **FUQ09F2**

9f3) Don't know .....  **FUQ09F3**

9f4) Don't remember .....  **FUQ09F4**

9g) Were you admitted to the hospital? .....  **FUQ09G**

If participant was admitted to hospital:

ID NUMBER:

FORM CODE: **FUQ**  
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SEQ#

10a) What was the date of this event?.....   /   /       **FUQ10A**

10b) What is the name of the medical facility? **Removed from Blinded Dataset**

10c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

10d) For clarification of our records, under what name is this record?

10d1) First Name: **Removed from Blinded Dataset**

10d2) Second Name: **Removed from Blinded Dataset**

10d3) Last Name: **Removed from Blinded Dataset**

10d4) Maternal Last Name: **Removed from Blinded Dataset**

11) (do not ask) Did the participant have a fourth episode? (if 'No', go to 20) .....  **FUQ11**

12) For the fourth episode of breathing problems you had since (date):

12a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ12A**

12b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ12B**

12c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ12C**

12d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **FUQ12D**

12e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ12E**

During that visit were you given (check all that apply):

12e1) An additional antibiotic .....  **FUQ12E1**

12e2) Additional steroids .....  **FUQ12E2**

12e3) Don't know .....  **FUQ12E3**

12e4) Don't remember .....  **FUQ12E4**

12f) Were you evaluated in an Emergency Department? .....  **FUQ12F**

During that visit were you given (check all that apply):

12f1) An additional antibiotic .....  **FUQ12F1**

12f2) Additional steroids .....  **FUQ12F2**

12f3) Don't know .....  **FUQ12F3**

12f4) Don't remember .....  **FUQ12F4**

12g) Were you admitted to the hospital? .....  **FUQ12G**



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15g) Were you admitted to the hospital? .....  **FUQ15G**

If participant was admitted to hospital:

16a) What was the date of this event?.....   /   /      **FUQ16A**

16b) What is the name of the medical facility? **Removed from Blinded Dataset**

16c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

16d) For clarification of our records, under what name is this record?

16d1) First Name: **Removed from Blinded Dataset**

16d2) Second Name: **Removed from Blinded Dataset**

16d3) Last Name: **Removed from Blinded Dataset**

16d4) Maternal Last Name: **Removed from Blinded Dataset**

17) (do not ask) Did the participant have a sixth episode? (if 'No', go to 20) .....  **FUQ17**

18) For the sixth episode of breathing problems you had since (date):

18a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ18A**

18b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ18B**

18c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ18C**

18d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **FUQ18D**

18e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ18E**

During that visit were you given (check all that apply):

18e1) An additional antibiotic .....  **FUQ18E1**

18e2) Additional steroids .....  **FUQ18E2**

18e3) Don't know .....  **FUQ18E3**

18e4) Don't remember .....  **FUQ18E4**

18f) Were you evaluated in an Emergency Department? .....  **FUQ18F**

During that visit were you given (check all that apply):

18f1) An additional antibiotic .....  **FUQ18F1**

18f2) Additional steroids .....  **FUQ18F2**

18f3) Don't know .....  **FUQ18F3**



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18f4) Don't remember.....  **FUQ18F4**

18g) Were you admitted to the hospital? .....  **FUQ18G**

If participant was admitted to hospital:

19a) What was the date of this event?.....   /   /      **FUQ19A**

19b) What is the name of the medical facility? **Removed from Blinded Dataset**

19c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

19d) For clarification of our records, under what name is this record?

19d1) First Name: **Removed from Blinded Dataset**

19d2) Second Name: **Removed from Blinded Dataset**

19d3) Last Name: **Removed from Blinded Dataset**

19d4) Maternal Last Name: **Removed from Blinded Dataset**

**INTERVIEWER:** (For non-COPD participants only) "The following questions are about any hospitalizations you may have had since your last (*center visit or telephone contact*) on (*date*)."

20) Since your last (*center visit or telephone contact*) on (*date*), have you at any time been admitted to a hospital (For COPD Participants: *for any reason other than a chest flare up*)? **FUQ20**

No 0  → **Go to Item 27**

Yes 1

Unsure 9  → **Go to Item 27**

20a) How many hospitalizations have you had since (*date*)?.....  **FUQ20A**

**INTERVIEWER:** The next few questions are about one event. If there were more than one we would like to talk about each one separately. Let's start with the first event after your (*visit or teleconference*) on (*date*)."

21a) What was the date of this event? .....   /   /      **FUQ21A**

21b) What is the name of the medical facility? **Removed from Blinded Dataset**

21c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

21d) For clarification of our records, under what name is this record?

21d1) First Name: **Removed from Blinded Dataset**

21d2) Second Name: **Removed from Blinded Dataset**

21d3) Last Name: **Removed from Blinded Dataset**

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21d4) Maternal Last Name: Removed from Blinded Dataset

21e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ21E**  
Yes 1

22a) What was the date of this event? .....   /   /     **FUQ22A**

22b) What is the name of the medical facility? Removed from Blinded Dataset

22c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

22d) For clarification of our records, under what name is this record?

22d1) First Name: Removed from Blinded Dataset

22d2) Second Name: Removed from Blinded Dataset

22d3) Last Name: Removed from Blinded Dataset

22d4) Maternal Last Name: Removed from Blinded Dataset

22e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ22E**  
Yes 1

23a) What was the date of this event? .....   /   /     **FUQ23A**

23b) What is the name of the medical facility? Removed from Blinded Dataset

23c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

23d) For clarification of our records, under what name is this record?

23d1) First Name: Removed from Blinded Dataset

23d2) Second Name: Removed from Blinded Dataset

23d3) Last Name: Removed from Blinded Dataset

23d4) Maternal Last Name: Removed from Blinded Dataset

23e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ23E**  
Yes 1

24a) What was the date of this event? .....   /   /     **FUQ24A**

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24b) What is the name of the medical facility? Removed from Blinded Dataset

24c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

24d) For clarification of our records, under what name is this record?

24d1) First Name: Removed from Blinded Dataset

24d2) Second Name: Removed from Blinded Dataset

24d3) Last Name: Removed from Blinded Dataset

24d4) Maternal Last Name: Removed from Blinded Dataset

24e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **FUQ24E**  
Yes 1

25a) What was the date of this event? .....   /   /     **FUQ25A**

25b) What is the name of the medical facility? Removed from Blinded Dataset

25c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

25d) For clarification of our records, under what name is this record?

25d1) First Name: Removed from Blinded Dataset

25d2) Second Name: Removed from Blinded Dataset

25d3) Last Name: Removed from Blinded Dataset

25d4) Maternal Last Name: Removed from Blinded Dataset

25e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **FUQ25E**  
Yes 1

26a) What was the date of this event? .....   /   /     **FUQ26A**

26b) What is the name of the medical facility? Removed from Blinded Dataset

26c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

26d) For clarification of our records, under what name is this record?

26d1) First Name: Removed from Blinded Dataset

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26d2) Second Name: Removed from Blinded Dataset

26d3) Last Name: Removed from Blinded Dataset

26d4) Maternal Last Name: Removed from Blinded Dataset

**INTERVIEWER:** I'd now like to ask you some other questions about your health since your last (*clinic visit or telephone contact*) on (*date*).

(Questions 27-28 are for COPD participants only.)

Since your last (*clinic visit or telephone contact*) on (*date*)

27) Did your doctor put you on oxygen? (Y/N) .....  **FUQ27**

28) Have you been listed for or received a lung transplant? (Y/N) .....  **FUQ28**

29) Are you currently smoking cigarettes? (Y/N) .....  **FUQ29**

30) Since your last (*clinic visit or telephone contact*) on (*date*), have you been diagnosed with other medical problems or been injured? (Y/ N) .....  **FUQ30**

If answered 'Yes' to question 30

31) Were you diagnosed with:

31a) Lung cancer (Y/N) .....  **FUQ31A**

31b) Other type of cancer (Y/N) .....  **FUQ31B**

If so, what type? FUQ31B1

31c) Diabetes (Y/N) .....  **FUQ31C**

31d) Blood Clots (Y/N) .....  **FUQ31D**

31e) Osteoporosis (Y/N) .....  **FUQ31E**

31f) Broken Hip (Y/N) .....  **FUQ31F**

31g) Heart attack or myocardial infarction (Y/N) .....  **FUQ31G**

31h) Stroke (Y/N) .....  **FUQ31H**

31i) Coronary artery disease (atherosclerosis) (Y/N) .....  **FUQ31I**

**INTERVIEWER:** "Thank you very much for your participation in the SPIROMICS study. I'd like to ask you just a few more questions to make sure our contact information for you is up-to-date. All information you provide us is strictly confidential and will not be shared with anyone else."

32) Current home address: Removed from Blinded Dataset  
Address line 1: \_\_\_\_\_





# FOLLOW-UP QUESTIONNAIRE

ID NUMBER:	<b>BLINDID</b>			
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0a) Form Date .. **Month and Day Removed from Blinded Dataset** Initials **Removed from Blinded Dataset**

**Instructions:** This form should be completed during the follow up phone conversations with study participants. Read the form carefully to familiarize yourself with the script as well as questions and skip patterns.

**INTERVIEWER:** Hello, my name is *(interviewer name)*, and I am calling to follow up with *(participant name)* about the Subpopulations and Intermediate Outcome Measures in COPD Study (SPIROMICS), a health study in which s/he is currently enrolled. Is s/he available?

No ———> When would it be convenient to call back? .....Thank you. I will call again.

Yes ———> Hello, *(participant name)*, this is *(interviewer name)* with the SPIROMICS study. I'm calling to see how you have been since your last *(visit to our center or telephone contact)*. Do you have a few minutes to speak on the phone?

No ———> When would it be convenient to call back?.....Thank you. I will call again.

Yes ———> We'd like to gather information about your general health and about specific medical conditions that you may have had since your last *(visit to our center or telephone contact)*. I will ask you some questions about your health since your last *(visit to our center or telephone contact)* on *(date of contact)*.

**INTERVIEWER:** I want you to focus on what happened from *(date of contact)* until today.

- 1) *(Do not ask participant)* Participant status (choose one): **FUQ01**
- Contacted and alive  → **Go to Item 2**
  - Contacted and refused interview  → **End Call**
  - Not contacted, reported alive  → **End Call**
  - Not contacted, reported deceased  → **Go to Item 1a**
  - Not contacted, left message  → **End Call**
  - Not contacted, unable to leave message  → **End Call**
  - Not contacted, phone line disconnected  → **End Call**
  - Unknown  → **End Call**

1a) What was the date of death?..... **Month and Day Removed from Blinded Dataset**

1b) What city, state, and country did the death occur? \_\_\_\_\_ **Removed from Blinded Dataset**

1c) Do you know if *(insert decedent's name)* was hospitalized or visited an emergency room for any reason since *(date of last contact)* and his/her death?

- Yes 1  Record date and name of hospitalization in question 21a. **FUQ01C**  
No 0  End interview

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### HOSPITALIZATIONS

2) Since your last (*clinic visit or telephone contact*) on (*date*), have you had a flare-up of your chest trouble? (Y/N).....  **FUQ02**  
(if 'No' go to item 20)

If Yes:

2a) How many episodes of chest trouble flare ups have you had since (*date*)?.....  **FUQ02A**

How was/were the episode(s) of breathing problem(s) treated? Please answer for each episode (if more than one) by checking all relevant treatments given for each episode. Starting with the first episode since (*date*):

3) For the first episode of breathing problems you had since (*date*):

3a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ3A**

3b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ3B**

3c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ3C**

3d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  **FUQ3D**

3e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ3E**

During that visit were you given (check all that apply):

3e1) An additional antibiotic .....  **FUQ03E1**

3e2) Additional steroids .....  **FUQ03E2**

3e3) Don't know .....  **FUQ03E3**

3e4) Don't remember .....  **FUQ03E4**

3f) Were you evaluated in an Emergency Department? .....  **FUQ03F**

During that visit were you given (check all that apply):

3f1) An additional antibiotic .....  **FUQ03F1**

3f2) Additional steroids .....  **FUQ03F2**

3f3) Don't know .....  **FUQ03F3**

3f4) Don't remember .....  **FUQ03F4**

3g) Were you admitted to the hospital? .....  **FUQ03G**

If participant was admitted to hospital:

4a) What was the date of this event? ..... **Month and Day Removed from Blinded Dataset**

4b) What is the name of the medical facility? — **Removed from Blinded Dataset** —

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4c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

4d) For clarification of our records, under what name is this record?

4d1) First Name: Removed from Blinded Dataset

4d2) Second Name: Removed from Blinded Dataset

4d3) Last Name: Removed from Blinded Dataset

4d4) Maternal Last Name: Removed from Blinded Dataset

5) (do not ask) Did the participant have a second episode? (if 'No', go to 20) .....  **FUQ05**

6) For the second episode of breathing problems you had since (date):

6a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ06A**

6b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ06B**

6c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ06C**

6d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  **FUQ06D**

6e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ06E**

During that visit were you given (check all that apply):

6e1) An additional antibiotic .....  **FUQ06E1**

6e2) Additional steroids .....  **FUQ06E2**

6e3) Don't know .....  **FUQ06E3**

6e4) Don't remember .....  **FUQ06E4**

6f) Were you evaluated in an Emergency Department? .....  **FUQ06F**

During that visit were you given (check all that apply):

6f1) An additional antibiotic .....  **FUQ06F1**

6f2) Additional steroids .....  **FUQ06F2**

6f3) Don't know .....  **FUQ06F3**

6f4) Don't remember .....  **FUQ06F4**

If participant was admitted to hospital:

7a) What was the date of this event? ..... Month and Day Removed from Blinded Dataset

7b) What is the name of the medical facility? Removed from Blinded Dataset



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7c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

7d) For clarification of our records, under what name is this record?

7d1) First Name: **Removed from Blinded Dataset**

7d2) Second Name: **Removed from Blinded Dataset**

7d3) Last Name: **Removed from Blinded Dataset**

7d4) Maternal Last Name: **Removed from Blinded Dataset**

8) (do not ask) Did the participant have a third episode? (if 'No', go to 20) .....  **FUQ08**

9) For the third episode of breathing problems you had since (date):

9a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ09A**

9b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ09B**

9c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ09C**

9d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  **FUQ09D**

9e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ09E**

During that visit were you given (check all that apply):

9e1) An additional antibiotic .....  **FUQ09E1**

9e2) Additional steroids .....  **FUQ09E2**

9e3) Don't know .....  **FUQ09E3**

9e4) Don't remember .....  **FUQ09E4**

9f) Were you evaluated in an Emergency Department? .....  **FUQ09F**

During that visit were you given (check all that apply):

9f1) An additional antibiotic .....  **FUQ09F1**

9f2) Additional steroids .....  **FUQ09F2**

9f3) Don't know .....  **FUQ09F3**

9f4) Don't remember .....  **FUQ09F4**

9g) Were you admitted to the hospital? .....  **FUQ09G**

If participant was admitted to hospital:

10a) What was the date of this event? ..... **Month and Day Removed from Blinded Dataset**

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10b) What is the name of the medical facility? Removed from Blinded Dataset

10c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

10d) For clarification of our records, under what name is this record?

10d1) First Name: Removed from Blinded Dataset

10d2) Second Name: Removed from Blinded Dataset

10d3) Last Name: Removed from Blinded Dataset

10d4) Maternal Last Name: Removed from Blinded Dataset

11) (do not ask) Did the participant have a fourth episode? (if 'No', go to 20).....  **FUQ11**

12) For the fourth episode of breathing problems you had since (date):

12a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ12A**

12b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ12B**

12c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ12C**

12d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  **FUQ12D**

12e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ12E**

During that visit were you given (check all that apply):

12e1) An additional antibiotic .....  **FUQ12E1**

12e2) Additional steroids .....  **FUQ12E2**

12e3) Don't know .....  **FUQ12E3**

12e4) Don't remember .....  **FUQ12E4**

12f) Were you evaluated in an Emergency Department? .....  **FUQ12F**

During that visit were you given (check all that apply):

12f1) An additional antibiotic .....  **FUQ12F1**

12f2) Additional steroids .....  **FUQ12F2**

12f3) Don't know .....  **FUQ12F3**

12f4) Don't remember .....  **FUQ12F4**

12g) Were you admitted to the hospital? .....  **FUQ12G**

If participant was admitted to hospital:

13a) What was the date of this event? .... Month and Day Removed from Blinded Dataset



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- 16b) What is the name of the medical facility? Removed from Blinded Dataset
- 16c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)
- 16d) For clarification of our records, under what name is this record?
- 16d1) First Name: Removed from Blinded Dataset
- 16d2) Second Name: Removed from Blinded Dataset
- 16d3) Last Name: Removed from Blinded Dataset
- 16d4) Maternal Last Name: Removed from Blinded Dataset
- 17) (do not ask) Did the participant have a sixth episode? (if 'No', go to 20).....  FUQ17
- 18) For the sixth episode of breathing problems you had since (date):
- 18a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  FUQ18A
- 18b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  FUQ18B
- 18c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  FUQ18C
- 18d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  FUQ18D
- 18e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  FUQ18E
- During that visit were you given (check all that apply):
- 18e1) An additional antibiotic .....  FUQ18E1
- 18e2) Additional steroids .....  FUQ18E2
- 18e3) Don't know .....  FUQ18E3
- 18e4) Don't remember .....  FUQ18E4
- 18f) Were you evaluated in an Emergency Department? .....  FUQ18F
- During that visit were you given (check all that apply):
- 18f1) An additional antibiotic .....  FUQ18F1
- 18f2) Additional steroids .....  FUQ18F2
- 18f3) Don't know .....  FUQ18F3
- 18f4) Don't remember .....  FUQ18F4
- 18g) Were you admitted to the hospital? .....  FUQ18G

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If participant was admitted to hospital:

19a) What was the date of this event? .....  **Month and Day Removed from Blinded Dataset**

19b) What is the name of the medical facility?  **Removed from Blinded Dataset**

19c) What is the address of this medical facility?  **Removed from Blinded Dataset**  
(Leave blank if unknown)

19d) For clarification of our records, under what name is this record?

19d1) First Name:  **Removed from Blinded Dataset**

19d2) Second Name:  **Removed from Blinded Dataset**

19d3) Last Name:  **Removed from Blinded Dataset**

19d4) Maternal Last Name:  **Removed from Blinded Dataset**

**INTERVIEWER:** "The following questions are about any other hospitalizations you may have had since your last (*center visit or telephone contact*) on (*date*)."

20) Since your last (*center visit or telephone contact*) on (*date*), have you at any time been admitted to a hospital for any reason other than a chest flare up?  **FUQ20**

No 0  → **Go to Item 27**

Yes 1

Unsure 9  → **Go to Item 27**

20a) How many hospitalizations have you had since (*date*)? .....  **FUQ20A**

**INTERVIEWER:** The next few questions are about one event. If there was more than one we would like to talk about each one separately. Let's start with the first event after your (*visit or teleconference*) on (*date*)."

21a) What was the date of this event? .....  **Month and Day Removed from Blinded Dataset**

21b) What is the name of the medical facility?  **Removed from Blinded Dataset**

21c) What is the address of this medical facility?  **Removed from Blinded Dataset**  
(Leave blank if unknown)

21d) For clarification of our records, under what name is this record?

21d1) First Name:  **Removed from Blinded Dataset**

21d2) Second Name:  **Removed from Blinded Dataset**

21d3) Last Name:  **Removed from Blinded Dataset**

21d4) Maternal Last Name:  **Removed from Blinded Dataset**

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21e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ21E**  
Yes 1

22a) What was the date of this event? ..... **Month and Day Removed from Blinded Dataset**

22b) What is the name of the medical facility? **Removed from Blinded Dataset**

22c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

22d) For clarification of our records, under what name is this record?

22d1) First Name: **Removed from Blinded Dataset**

22d2) Second Name: **Removed from Blinded Dataset**

22d3) Last Name: **Removed from Blinded Dataset**

22d4) Maternal Last Name: **Removed from Blinded Dataset**

22e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ22E**  
Yes 1

23a) What was the date of this event? ..... **Month and Day Removed from Blinded Dataset**

23b) What is the name of the medical facility? **Removed from Blinded Dataset**

23c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

23d) For clarification of our records, under what name is this record?

23d1) First Name: **Removed from Blinded Dataset**

23d2) Second Name: **Removed from Blinded Dataset**

23d3) Last Name: **Removed from Blinded Dataset**

23d4) Maternal Last Name: **Removed from Blinded Dataset**

23e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ23E**  
Yes 1

24a) What was the date of this event? ..... **Month and Day Removed from Blinded Dataset**

24b) What is the name of the medical facility? **Removed from Blinded Dataset**

24c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

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24d) For clarification of our records, under what name is this record?

24d1) First Name: Removed from Blinded Dataset

24d2) Second Name: Removed from Blinded Dataset

24d3) Last Name: Removed from Blinded Dataset

24d4) Maternal Last Name: Removed from Blinded Dataset

24e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **FUQ24E**  
Yes 1

25a) What was the date of this event? ... Month and Day Removed from Blinded Dataset

25b) What is the name of the medical facility? Removed from Blinded Dataset

25c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

25d) For clarification of our records, under what name is this record?

25d1) First Name: Removed from Blinded Dataset

25d2) Second Name: Removed from Blinded Dataset

25d3) Last Name: Removed from Blinded Dataset

25d4) Maternal Last Name: Removed from Blinded Dataset

25e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **FUQ25E**  
Yes 1

26a) What was the date of this event? ... Month and Day Removed from Blinded Dataset

26b) What is the name of the medical facility? Removed from Blinded Dataset

26c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

26d) For clarification of our records, under what name is this record?

26d1) First Name: Removed from Blinded Dataset

26d2) Second Name: Removed from Blinded Dataset

26d3) Last Name: Removed from Blinded Dataset

26d4) Maternal Last Name: Removed from Blinded Dataset

ID NUMBER:									
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FORM CODE: **FUQ**  
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**INTERVIEWER:** I'd now like to ask you some other questions about your health since your last (*clinic visit or telephone contact*) on (*date*).

Since your last (*clinic visit or telephone contact*) on (*date*)

27) Did your doctor put you on oxygen? (Y/N) .....  **FUQ27**

28) Have you been listed for or received a lung transplant? (Y/N) .....  **FUQ28**

29) Are you currently smoking cigarettes? (Y/N).....  **FUQ29**

30) Since your last (*clinic visit or telephone contact*) on (*date*), have you been diagnosed with other medical problems or been injured? (Y/ N) .....  **FUQ30**

If answered 'Yes' to question 30

31) Were you diagnosed with:

31a) Lung cancer (Y/N) .....  **FUQ31A**

31b) Other type of cancer (Y/N).....  **FUQ31B**

If so, what type? **FUQ31B1** \_\_\_\_\_

31c) Diabetes (Y/N).....  **FUQ31C**

31d) Blood Clots (Y/N) .....  **FUQ31D**

31e) Osteoporosis (Y/N).....  **FUQ31E**

31f) Broken Hip (Y/N).....  **FUQ31F**

31g) Heart attack or myocardial infarction (Y/N) .....  **FUQ31G**

31h) Stroke (Y/N) .....  **FUQ31H**

31i) Coronary artery disease (atherosclerosis) (Y/N).....  **FUQ31I**



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**INTERVIEWER:** "Thank you very much for your participation in the SPIROMICS study. I am going to ask you for your current address, phone numbers, and email addresses. This is both to make sure we have the most current contact information for you as well as to help us examine the relationship between place of residence and COPD. Please remember that all information that you give us is confidential, and only certified SPIROMICS personnel will have access to this information."

32) Current home address:

Address line 1: Removed from Blinded Dataset

Address line 2: Removed from Blinded Dataset

City: Removed from Blinded Dataset State: Removed from Blinded Dataset

Zip Code: Removed from Blinded Dataset

a) When did you begin living here? ..... Removed from Blinded Dataset

33) Primary Phone Number: ..... ( Removed from Blinded Dataset )

a) Where does this number reach you (select only one)?

- Home..... 1
- Cell / Mobile..... 2
- Work..... 3

34) What is the best time of day to reach you at this number?

- Morning .....  FUQ34A
- Afternoon.....  FUQ34B
- Evening .....  FUQ34C

35) Secondary Phone Number: ..... ( Removed from Blinded Dataset )

a) Where does this number reach you (select only one)?

- Home..... 1
- Cell / Mobile..... 2
- Work..... 3

36) What is the best time of day to reach you at this number?

- Morning .....  FUQ36A
- Afternoon.....  FUQ36B
- Evening .....  FUQ36C

37) May we contact you via email in the future? (Y/N) ..... Removed from Blinded Dataset

a) What is the best email address at which to reach you?

Email: Removed from Blinded Dataset

b) What is another email address we could try?

Email: Removed from Blinded Dataset

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**LOCAL CONTACT 1**

38) a) Title: Removed b) First Name: Removed from Blinded Dataset  
c) Middle/Second Name: \_\_\_\_\_  
d) Last Name: Removed from Blinded Dataset  
e) Maternal Last Name: Removed from Blinded Dataset

39) Relationship: Removed from Blinded Dataset

40) Current home address of local contact:

a) Address line 1: Removed from Blinded Dataset  
b) Address line 2: Removed from Blinded Dataset  
c) City: Removed d) State: Removed from Blinded Dataset  
e) Zip Code: Removed from Blinded Dataset

41) Telephone: (Removed from Blinded Dataset) \_\_\_\_\_

42) Secondary Phone Number: (Removed from Blinded Dataset) \_\_\_\_\_

43) May we contact you via email in the future? (Y/N) ..... Removed from Blinded Dataset

a) What is the best email address at which to reach you?  
Email: Removed from Blinded Dataset

b) What is another email address we could try?  
Email: Removed from Blinded Dataset

**LOCAL CONTACT 2**

44) a) Title: Removed b) First Name: Removed from Blinded Dataset  
c) Middle/Second Name: Removed from Blinded Dataset  
d) Last Name: Removed from Blinded Dataset  
e) Maternal Last Name: Removed from Blinded Dataset

45) Relationship: Removed from Blinded Dataset

46) Current home address of local contact:

a) Address line 1: Removed from Blinded Dataset  
b) Address line 2: Removed from Blinded Dataset  
c) City: Removed d) State: Removed from Blinded Dataset  
e) Zip Code: Removed from Blinded Dataset

ID NUMBER:									
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47) Telephone: (

48) Secondary Phone Number: (

49) May we contact you via email in the future? (Y/N) .....

a) What is the best email address at which to reach you?

Email:

b) What is another email address we could try?

Email:

*Additional local contacts can be entered on the CIF.*

**INTERVIEWER:** "I would now like to ask you some questions related to potential future research studies including, potentially, studies of children of SPIROMICS participants."

50) Do you have any adult children whom we could contact? .....

- Yes ..... Y
- No ..... N
- Prefer not to respond ..... NR

51) Do you have any adult grandchildren whom we could contact?

- Yes ..... Y
- No ..... N
- Prefer not to respond ..... NR

52) Would you be interested in possibly joining a future study to test a new medication for COPD?

- Yes ..... Y
- No ..... N
- Unsure ..... U

**INTERVIEWER:** *Thank you for answering these questions.*

(If the next contact is by telephone): We'll be contacting you again around (*date*) for another telephone contact.

(If next contact is a clinic visit): We'll be contacting you around (*date*) to schedule an in-person visit at (*insert institution*) to take place around (*date*).

Thank you again for your time and participation.

(end call)



# FOLLOW-UP QUESTIONNAIRE

ID NUMBER: **BLINDID** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

FORM CODE: FUQ  
VERSION: 1.0 11/2/10

Visit Number **VISIT** SEQ # [ ] [ ] [ ]

0a) Form Date..... [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] **FUQ0A**

0b) Initials ..... [ ] [ ] [ ] **FUQ0B**

**Instructions:** This form should be completed during the follow up phone conversations with study participants. Read the form carefully to familiarize yourself with the script as well as questions and skip patterns.

**INTERVIEWER:** Hello, my name is (*interviewer name*), and I am calling to follow up with (*participant name*) about the Subpopulations and Intermediate Outcome Measures in COPD Study (SPIROMICS), a health study in which s/he is currently enrolled. Is s/he available?

No ———> When would it be convenient to call back? .....Thank you. I will call again.

Yes ———> Hello, (*participant name*), this is (*interviewer name*) with the SPIROMICS study. I'm calling to see how you have been since your last (*visit to our center or telephone contact*). Do you have a few minutes to speak on the phone?

No ———> When would it be convenient to call back?.....Thank you. I will call again.

Yes ———> We'd like to gather information about your general health and about specific medical conditions that you may have had since your last (*visit to our center or telephone contact*). I will ask you some questions about your health since your last (*visit to our center or telephone contact*) on (*date of contact*).

**INTERVIEWER:** I want you to focus on what happened from (*date of contact*) until today.

1) (*Do not ask participant*) Participant status (choose one): **FUQ01**

- Contacted and alive 1  → **Go to Item 2**
- Contacted and refused interview 2  → **End Call**
- Not contacted, reported alive 3  → **End Call**
- Not contacted, reported deceased 4  → **Go to Item 1a**
- Unknown 5  → **End Call**

1a) What was the date of death? ..... [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] **FUQ01A**

1b) What city, state, and country did the death occur? **Removed from Blinded Dataset** \_\_\_\_\_

1c) Do you know if (*insert decedent's name*) was hospitalized or visited an emergency room for any reason since (*date of last contact*) and his/her death? **FUQ01C**

- Yes 1  Record date and name of hospitalization in question 21a.
- No 0  End interview

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FORM CODE: **FUQ**  
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### HOSPITALIZATIONS

(If non-COPD participant, skip to question 20)

(For COPD Participants Only):

2) Since your last (*clinic visit or telephone contact*) on (*date*), have you had a flare-up of your chest trouble? (Y/N).....  **FUQ02**  
(if 'No' go to item 20)

If Yes:

2a) How many episodes of chest trouble flare ups have you had since (*date*)? .....  **FUQ02A**

How was/were the episode(s) of breathing problem(s) treated? Please answer for each episode (if more than one) by checking all relevant treatments given for each episode. Starting with the first episode since (*date*):

3) For the first episode of breathing problems you had since (*date*):

3a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ3A**

3b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ3B**

3c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ3C**

3d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **FUQ3D**

3e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ3E**

During that visit were you given (check all that apply):

3e1) An additional antibiotic .....  **FUQ03E1**

3e2) Additional steroids .....  **FUQ03E2**

3e3) Don't know .....  **FUQ03E3**

3e4) Don't remember .....  **FUQ03E4**

3f) Were you evaluated in an Emergency Department? .....  **FUQ03F**

During that visit were you given (check all that apply):

3f1) An additional antibiotic .....  **FUQ03F1**

3f2) Additional steroids .....  **FUQ03F2**

3f3) Don't know .....  **FUQ03F3**

3f4) Don't remember .....  **FUQ03F4**

3g) Were you admitted to the hospital? .....  **FUQ03G**

If participant was admitted to hospital:

4a) What was the date of this event? ..... // **FUQ04A**

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4b) What is the name of the medical facility?  **Removed from Blinded Dataset**

4c) What is the address of this medical facility?  **Removed from Blinded Dataset**  
(Leave blank if unknown)

4d) For clarification of our records, under what name is this record?

4d1) First Name:  **Removed from Blinded Dataset**

4d2) Second Name:  **Removed from Blinded Dataset**

4d3) Last Name:  **Removed from Blinded Dataset**

4d4) Maternal Last Name:  **Removed from Blinded Dataset**

5) (do not ask) Did the participant have a second episode? (if 'No', go to 20) .....  **FUQ05**

6) For the second episode of breathing problems you had since (date):

6a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ06A**

6b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ06B**

6c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ06C**

6d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  **FUQ06D**

6e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ06E**

During that visit were you given (check all that apply):

6e1) An additional antibiotic .....  **FUQ06E1**

6e2) Additional steroids .....  **FUQ06E2**

6e3) Don't know .....  **FUQ06E3**

6e4) Don't remember .....  **FUQ06E4**

6f) Were you evaluated in an Emergency Department? .....  **FUQ06F**

During that visit were you given (check all that apply):

6f1) An additional antibiotic .....  **FUQ06F1**

6f2) Additional steroids .....  **FUQ06F2**

6f3) Don't know .....  **FUQ06F3**

6f4) Don't remember .....  **FUQ06F4**

g) Where you admitted to the hospital  **FUQ06G**  
If participant was admitted to hospital:

7a) What was the date of this event? .....   /   /      **FUQ07A**

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7b) What is the name of the medical facility?  **Removed from Blinded Dataset**

7c) What is the address of this medical facility?  **Removed from Blinded Dataset**  
(Leave blank if unknown)

7d) For clarification of our records, under what name is this record?

7d1) First Name:  **Removed from Blinded Dataset**

7d2) Second Name:  **Removed from Blinded Dataset**

7d3) Last Name:  **Removed from Blinded Dataset**

7d4) Maternal Last Name:  **Removed from Blinded Dataset**

8) (do not ask) Did the participant have a third episode? (if 'No', go to 20) .....  **FUQ08**

9) For the third episode of breathing problems you had since (date):

9a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ09A**

9b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ09B**

9c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ09C**

9d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **FUQ09D**

9e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ09E**

During that visit were you given (check all that apply):

9e1) An additional antibiotic .....  **FUQ09E1**

9e2) Additional steroids .....  **FUQ09E2**

9e3) Don't know .....  **FUQ09E3**

9e4) Don't remember .....  **FUQ09E4**

9f) Were you evaluated in an Emergency Department? .....  **FUQ09F**

During that visit were you given (check all that apply):

9f1) An additional antibiotic .....  **FUQ09F1**

9f2) Additional steroids .....  **FUQ09F2**

9f3) Don't know .....  **FUQ09F3**

9f4) Don't remember .....  **FUQ09F4**

9g) Were you admitted to the hospital? .....  **FUQ09G**

If participant was admitted to hospital:







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SEQ #

15g) Were you admitted to the hospital? .....  **FUQ15G**

If participant was admitted to hospital:

16a) What was the date of this event?.....   /   /      **FUQ16A**

16b) What is the name of the medical facility? **Removed from Blinded Dataset**

16c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

16d) For clarification of our records, under what name is this record?

16d1) First Name: **Removed from Blinded Dataset**

16d2) Second Name: **Removed from Blinded Dataset**

16d3) Last Name: **Removed from Blinded Dataset**

16d4) Maternal Last Name: **Removed from Blinded Dataset**

17) (do not ask) Did the participant have a sixth episode? (if 'No', go to 20) .....  **FUQ17**

18) For the sixth episode of breathing problems you had since (date):

18a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **FUQ18A**

18b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **FUQ18B**

18c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **FUQ18C**

18d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **FUQ18D**

18e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **FUQ18E**

During that visit were you given (check all that apply):

18e1) An additional antibiotic .....  **FUQ18E1**

18e2) Additional steroids .....  **FUQ18E2**

18e3) Don't know .....  **FUQ18E3**

18e4) Don't remember .....  **FUQ18E4**

18f) Were you evaluated in an Emergency Department? .....  **FUQ18F**

During that visit were you given (check all that apply):

18f1) An additional antibiotic .....  **FUQ18F1**

18f2) Additional steroids .....  **FUQ18F2**

18f3) Don't know .....  **FUQ18F3**

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18f4) Don't remember.....  **FUQ18F4**

18g) Were you admitted to the hospital? .....  **FUQ18G**

If participant was admitted to hospital:

19a) What was the date of this event?.....   /   /      **FUQ19A**

19b) What is the name of the medical facility? **Removed from Blinded Dataset**

19c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

19d) For clarification of our records, under what name is this record?

19d1) First Name: **Removed from Blinded Dataset**

19d2) Second Name: **Removed from Blinded Dataset**

19d3) Last Name: **Removed from Blinded Dataset**

19d4) Maternal Last Name: **Removed from Blinded Dataset**

**INTERVIEWER:** (For non-COPD participants only) "The following questions are about any hospitalizations you may have had since your last (*center visit or telephone contact*) on (*date*)."

20) Since your last (*center visit or telephone contact*) on (*date*), have you at any time been admitted to a hospital (For COPD Participants: *for any reason other than a chest flare up*)? **FUQ20**

No 0  → **Go to Item 27**

Yes 1

Unsure 9  → **Go to Item 27**

20a) How many hospitalizations have you had since (*date*)?.....  **FUQ20A**

**INTERVIEWER:** The next few questions are about one event. If there were more than one we would like to talk about each one separately. Let's start with the first event after your (*visit or teleconference*) on (*date*)."

21a) What was the date of this event? .....   /   /      **FUQ21A**

21b) What is the name of the medical facility? **Removed from Blinded Dataset**

21c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

21d) For clarification of our records, under what name is this record?

21d1) First Name: **Removed from Blinded Dataset**

21d2) Second Name: **Removed from Blinded Dataset**

21d3) Last Name: **Removed from Blinded Dataset**

ID NUMBER:

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21d4) Maternal Last Name: Removed from Blinded Dataset

21e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ21E**  
Yes 1

22a) What was the date of this event? .....   /   /     **FUQ22A**

22b) What is the name of the medical facility? Removed from Blinded Dataset

22c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

22d) For clarification of our records, under what name is this record?

22d1) First Name: Removed from Blinded Dataset

22d2) Second Name: Removed from Blinded Dataset

22d3) Last Name: Removed from Blinded Dataset

22d4) Maternal Last Name: Removed from Blinded Dataset

22e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ22E**  
Yes 1

23a) What was the date of this event? .....   /   /     **FUQ23A**

23b) What is the name of the medical facility? Removed from Blinded Dataset

23c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

23d) For clarification of our records, under what name is this record?

23d1) First Name: Removed from Blinded Dataset

23d2) Second Name: Removed from Blinded Dataset

23d3) Last Name: Removed from Blinded Dataset

23d4) Maternal Last Name: Removed from Blinded Dataset

23e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **FUQ23E**  
Yes 1

24a) What was the date of this event? .....   /   /     **FUQ24A**

ID NUMBER:

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Visit Number

SEQ #

24b) What is the name of the medical facility? Removed from Blinded Dataset

24c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

24d) For clarification of our records, under what name is this record?

24d1) First Name: Removed from Blinded Dataset

24d2) Second Name: Removed from Blinded Dataset

24d3) Last Name: Removed from Blinded Dataset

24d4) Maternal Last Name: Removed from Blinded Dataset

24e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **FUQ24E**  
Yes 1

25a) What was the date of this event? .....   /   /     **FUQ25A**

25b) What is the name of the medical facility? Removed from Blinded Dataset

25c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

25d) For clarification of our records, under what name is this record?

25d1) First Name: Removed from Blinded Dataset

25d2) Second Name: Removed from Blinded Dataset

25d3) Last Name: Removed from Blinded Dataset

25d4) Maternal Last Name: Removed from Blinded Dataset

25e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **FUQ25E**  
Yes 1

26a) What was the date of this event? .....   /   /     **FUQ26A**

26b) What is the name of the medical facility? Removed from Blinded Dataset

26c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

26d) For clarification of our records, under what name is this record?

26d1) First Name: Removed from Blinded Dataset

ID NUMBER:

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26d2) Second Name: Removed from Blinded Dataset

26d3) Last Name: Removed from Blinded Dataset

26d4) Maternal Last Name: Removed from Blinded Dataset

**INTERVIEWER:** I'd now like to ask you some other questions about your health since your last (*clinic visit or telephone contact*) on (*date*).

(Questions 27-28 are for COPD participants only.)

Since your last (*clinic visit or telephone contact*) on (*date*)

27) Did your doctor put you on oxygen? (Y/N) .....  **FUQ27**

28) Have you been listed for or received a lung transplant? (Y/N) .....  **FUQ28**

29) Are you currently smoking cigarettes? (Y/N) .....  **FUQ29**

30) Since your last (*clinic visit or telephone contact*) on (*date*), have you been diagnosed with other medical problems or been injured? (Y/ N) .....  **FUQ30**

If answered 'Yes' to question 30

31) Were you diagnosed with:

31a) Lung cancer (Y/N) .....  **FUQ31A**

31b) Other type of cancer (Y/N) .....  **FUQ31B**

If so, what type? FUQ31B1

31c) Diabetes (Y/N) .....  **FUQ31C**

31d) Blood Clots (Y/N) .....  **FUQ31D**

31e) Osteoporosis (Y/N) .....  **FUQ31E**

31f) Broken Hip (Y/N) .....  **FUQ31F**

31g) Heart attack or myocardial infarction (Y/N) .....  **FUQ31G**

31h) Stroke (Y/N) .....  **FUQ31H**

31i) Coronary artery disease (atherosclerosis) (Y/N) .....  **FUQ31I**

**INTERVIEWER:** "Thank you very much for your participation in the SPIROMICS study. I'd like to ask you just a few more questions to make sure our contact information for you is up-to-date. All information you provide us is strictly confidential and will not be shared with anyone else."

32) Current home address: Removed from Blinded Dataset  
Address line 1: \_\_\_\_\_

ID NUMBER:

FORM CODE: **FUQ**  
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Visit Number

SEQ #

Address line 2:

City:  State:

Zip Code:

a) When did you begin living here? ..... //

33) Primary Phone Number: ..... (  )

34) What is the best time of day to reach you at this number?

Morning .....

Afternoon.....

Evening .....

35) Secondary Phone Number: ..... (  )

36) What is the best time of day to reach you at this number?

Morning .....

Afternoon.....

Evening .....

**INTERVIEWER:** *Thank you for answering these questions.*

(If the next contact is by telephone): We'll be contacting you again around (*date*) for another telephone contact.

(If next contact is a clinic visit): We'll be contacting you around (*date*) to schedule an in-person visit at (*insert institution*) to take place around (*date*).

Thank you again for your time and participation.

(end call)





ID NUMBER:									
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Visit Number		
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- 5) Worrying thoughts go through my mind .....  **HDS05**  
    A great deal of the time .....3  
    A lot of the time .....2  
    Not too often .....1  
    Very little .....0
- 6) I feel cheerful.....  **HDS06**  
    Never .....3  
    Not often .....2  
    Sometimes .....1  
    Most of the time.....0
- 7) I can sit at ease and feel relaxed .....  **HDS07**  
    Definitely .....0  
    Usually .....1  
    Not Often.....2  
    Not at all.....3
- 8) I feel as if I am slowed down.....  **HDS08**  
    Nearly all the time .....3  
    Very often .....2  
    Sometimes .....1  
    Not at all.....0
- 9) I get a sort of frightened feeling like 'butterflies' in the stomach .....  **HDS09**  
    Not at all.....0  
    Occasionally .....1  
    Quite Often.....2  
    Very Often.....3
- 10) I have lost interest in my appearance .....  **HDS10**  
    Definitely .....3  
    I don't take as much care as I should .....2  
    I may not take quite as much care.....1  
    I take just as much care as ever .....0

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- 11) I feel restless as I have to be on the move.....  **HDS11**  
Very much indeed .....3  
Quite a lot .....2  
Not very much.....1  
Not at all.....0
- 12) I look forward with enjoyment to things .....  **HDS12**  
As much as I ever did.....0  
Rather less than I used to .....1  
Definitely less than I used to .....2  
Hardly at all.....3
- 13) I get sudden feelings of panic .....  **HDS13**  
Very often indeed .....3  
Quite often .....2  
Not very often.....1  
Not at all.....0
- 14) I can enjoy a good book or radio or TV program .....  **HDS14**  
Often .....0  
Sometimes .....1  
Not often .....2  
Very seldom .....3

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During that visit were you given (check all that apply):

- 2f1) An additional antibiotic .....  HEF2F1
- 2f2) Additional steroids .....  HEF2F2
- 2f3) Don't know .....  HEF2F3
- 2f4) Don't remember .....  HEF2F4

2g) Were you admitted to the hospital? .....  HEF2G

If participant was admitted to hospital:

3a) What was the date of this event? .....   /   /     HEF3A

3b) What is the name of the medical facility? HEF3B \_\_\_\_\_

3c) What is the address of this medical facility? HEF3C \_\_\_\_\_  
(Leave blank if unknown)

3d) For clarification of our records, under what name is this record?

3d1) First Name: HEF3D1 \_\_\_\_\_

3d2) Second Name: HEF3D2 \_\_\_\_\_

3d3) Last Name: HEF3D3 \_\_\_\_\_

3d4) Maternal Last Name: HEF3D4 \_\_\_\_\_

4) (do not ask) Did the participant have a second episode? (if 'No', go to 19) .....  HEF4

5) For the second episode of breathing problems you had since (date):

5a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  HEF5A

5b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  HEF5B

5c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  HEF5C

5d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  HEF5D

5e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  HEF5E

During that visit were you given (check all that apply):

- 5e1) An additional antibiotic .....  HEF5E1
- 5e2) Additional steroids .....  HEF5E2
- 5e3) Don't know .....  HEF5E3
- 5e4) Don't remember .....  HEF5E4

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- 5f) Were you evaluated in an Emergency Department? .....  HEF5F
- During that visit were you given (check all that apply):
- 5f1) An additional antibiotic .....  HEF5F1
  - 5f2) Additional steroids .....  HEF5F2
  - 5f3) Don't know .....  HEF5F3
  - 5f4) Don't remember .....  HEF5F4
- 5g) Were you admitted to the hospital? .....  HEF5G

- If participant was admitted to hospital:
- 6a) What was the date of this event? ..... / /     HEF6A
- 6b) What is the name of the medical facility? HEF6B
- 6c) What is the address of this medical facility? HEF6C  
(Leave blank if unknown)
- 6d) For clarification of our records, under what name is this record?
- 6d1) First Name: HEF6D1
  - 6d2) Second Name: HEF6D2
  - 6d3) Last Name: HEF6D3
  - 6d4) Maternal Last Name: HEF6D4

- 7) (do not ask) Did the participant have a third episode? (if 'No', go to 19) .....  HEF7
- 8) For the third episode of breathing problems you had since (date):
- 8a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  HEF8A
  - 8b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  HEF8B
  - 8c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  HEF8C
  - 8d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  HEF8D
  - 8e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  HEF8E
- During that visit were you given (check all that apply):
- 8e1) An additional antibiotic .....  HEF8E1
  - 8e2) Additional steroids .....  HEF8E2
  - 8e3) Don't know .....  HEF8E3

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- 8e4) Don't remember .....  HEF8E4
- 8f) Were you evaluated in an Emergency Department? .....  HEF8F
- During that visit were you given (check all that apply):
- 8f1) An additional antibiotic .....  HEF8F1
- 8f2) Additional steroids .....  HEF8F2
- 8f2) Don't know .....  HEF8F3
- 8f4) Don't remember .....  HEF8F4
- 8g) Were you admitted to the hospital? .....  HEF8G

If participant was admitted to hospital:

- 9a) What was the date of this event? .....   /   /     HEF9A
- 9b) What is the name of the medical facility? HEF9B \_\_\_\_\_
- 9c) What is the address of this medical facility? HEF9C \_\_\_\_\_  
(Leave blank if unknown)
- 9d) For clarification of our records, under what name is this record?
- 9d1) First Name: HEF9D1 \_\_\_\_\_
- 9d2) Second Name: HEF9D2 \_\_\_\_\_
- 9d3) Last Name: HEF9D3 \_\_\_\_\_
- 9d4) Maternal Last Name: HEF9D4 \_\_\_\_\_
- 10) (do not ask) Did the participant have a fourth episode? (if 'No', go to 19) .....  HEF10
- 11) For the fourth episode of breathing problems you had since (date):
- 11a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  HEF11A
- 11b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N) .....  HEF11B
- 11c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  HEF11C
- 11d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  HEF11D
- 11e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  HEF11E
- During that visit were you given (check all that apply):
- 11e1) An additional antibiotic .....  HEF11E1
- 11e2) Additional steroids .....  HEF11E2



ID NUMBER:

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14e2) Additional steroids .....  HEF14E2

14e3) Don't know .....  HEF14E3

14e4) Don't remember .....  HEF14E4

14f) Were you evaluated in an Emergency Department? .....  HEF14F

During that visit were you given (check all that apply):

14f1) An additional antibiotic .....  HEF14F1

14f2) Additional steroids .....  HEF14F2

14f3) Don't know .....  HEF14F3

14f4) Don't remember .....  HEF14F4

14g) Were you admitted to the hospital? .....  HEF14G

If participant was admitted to hospital:

15a) What was the date of this event?..... / /     HEF15A

15b) What is the name of the medical facility? HEF15B \_\_\_\_\_

15c) What is the address of this medical facility? HEF15C \_\_\_\_\_  
(Leave blank if unknown)

15d) For clarification of our records, under what name is this record?

15d1) First Name: HEF15D1 \_\_\_\_\_

15d2) Second Name: HEF15D2 \_\_\_\_\_

15d3) Last Name: HEF15D3 \_\_\_\_\_

15d4) Maternal Last Name: HEF15D4 \_\_\_\_\_

16) (do not ask) Did the participant have a sixth episode? (if 'No', go to 19).....  HEF16

17) For the sixth episode of breathing problems you had since (date):

17a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  HEF17A

17b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  HEF17B

17c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  HEF17C

17d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N)....  HEF17D

17e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  HEF17E

During that visit were you given (check all that apply):



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- 17e1) An additional antibiotic .....  HEF17E1
- 17e2) Additional steroids .....  HEF17E2
- 17e3) Don't know .....  HEF17E3
- 17e4) Don't remember .....  HEF17E4
- 17f) Were you evaluated in an Emergency Department? .....  HEF17F  
During that visit were you given (check all that apply):
  - 17f1) An additional antibiotic .....  HEF17F1
  - 17f2) Additional steroids .....  HEF17F2
  - 17f3) Don't know .....  HEF17F3
  - 17f4) Don't remember .....  HEF17F4
- 17g) Were you admitted to the hospital? .....  HEF17G

If participant was admitted to hospital:

- 18a) What was the date of this event?..... / /   HEF18A
- 18b) What is the name of the medical facility?  HEF18B
- 18c) What is the address of this medical facility?  HEF18C  
(Leave blank if unknown)
- 18d) For clarification of our records, under what name is this record?
  - 18d1) First Name:  HEF18D1
  - 18d2) Second Name:  HEF18D2
  - 18d3) Last Name:  HEF18D3
  - 18d4) Maternal Last Name:  HEF18D4

**INTERVIEWER:** (Read prompt for non-COPD participants only) "The following questions are about any hospitalizations you may have had since your last (*center visit or telephone contact*) on (*date*)."

- 19) Since your last (*center visit or telephone contact*) on (*date*), have you at any time been admitted to a hospital (For COPD Participants: *for any reason other than a chest flare up*)?
  - No 0  →  HEF19
  - Yes 1
  - Unsure 9  →

- 20) How many hospitalizations have you had since (*date*)? .....  HEF20

**INTERVIEWER:** The next few questions are about one event. If there were more than one we would like to talk about each one separately. Let's start with the first event after your (*visit or teleconference*) on (*date*)."

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21a) What was the date of this event? .....   /   /       **HEF21A**

21b) What is the name of the medical facility? **HEF21B** \_\_\_\_\_

21c) What is the address of this medical facility? **HEF21C** \_\_\_\_\_  
(Leave blank if unknown)

21d) For clarification of our records, under what name is this record?

21d1) First Name: **HEF21D1** \_\_\_\_\_

21d2) Second Name: **HEF21D2** \_\_\_\_\_

21d3) Last Name: **HEF21D3** \_\_\_\_\_

21d4) Maternal Last Name: **HEF21D4** \_\_\_\_\_

21e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to End** **HEF21E**  
Yes 1

22a) What was the date of this event? .....   /   /       **HEF22A**

22b) What is the name of the medical facility? **HEF22B** \_\_\_\_\_

22c) What is the address of this medical facility? **HEF22C** \_\_\_\_\_  
(Leave blank if unknown)

22d) For clarification of our records, under what name is this record?

22d1) First Name: **HEF22D1** \_\_\_\_\_

22d2) Second Name: **HEF22D2** \_\_\_\_\_

22d3) Last Name: **HEF22D3** \_\_\_\_\_

22d4) Maternal Last Name: **HEF22D4** \_\_\_\_\_

22e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to End** **HEF22E**  
Yes 1

23a) What was the date of this event? .....   /   /       **HEF23A**

23b) What is the name of the medical facility? **HEF23B** \_\_\_\_\_

23c) What is the address of this medical facility? **HEF23C** \_\_\_\_\_  
(Leave blank if unknown)

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23d) For clarification of our records, under what name is this record?

23d1) First Name: HEF23D1

23d2) Second Name: HEF23D2

23d3) Last Name: HEF23D3

23d4) Maternal Last Name: HEF23D4

23e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to End** HEF23E  
Yes 1

24a) What was the date of this event?..... // HEF24A

24b) What is the name of the medical facility? HEF24B

24c) What is the address of this medical facility? HEF24C  
(Leave blank if unknown)

24d) For clarification of our records, under what name is this record?

24d1) First Name: HEF24D1

24d2) Second Name: HEF24D2

24d3) Last Name: HEF24D3

24d4) Maternal Last Name: HEF24D4

24e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to End** HEF24E  
Yes 1

25a) What was the date of this event?..... // HEF25A

25b) What is the name of the medical facility? HEF25B

25c) What is the address of this medical facility? HEF25C  
(Leave blank if unknown)

25d) For clarification of our records, under what name is this record?

25d1) First Name: HEF25D1

25d2) Second Name: HEF25D2

25d3) Last Name: HEF25D3

25d4) Maternal Last Name: HEF25D4

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25e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to End** HEF25E  
Yes 1

26a) What was the date of this event? .....   /   /     HEF26A

26b) What is the name of the medical facility? HEF26B \_\_\_\_\_

26c) What is the address of this medical facility? HEF26C \_\_\_\_\_  
(Leave blank if unknown)

26d) For clarification of our records, under what name is this record?

26d1) First Name: HEF26D1 \_\_\_\_\_

26d2) Second Name: HEF26D2 \_\_\_\_\_

26d3) Last Name: HEF26D3 \_\_\_\_\_

26d4) Maternal Last Name: HEF26D4 \_\_\_\_\_



# SPIROMICS HIP FRACTURE ABSTRACTION FORM (HFF)

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FORM CODE: HFF VERSION: A 2/12/2015	Visit Number	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
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0a. Completion Date: / /  **HFF0A**      0b. Staff ID:  **HFF0B**  
 Month/Day/Year

0c. Event ID:  **HFF0C**      0d. Event Date: / /  **HFF0D**

Instructions: *Answers are derived from the medical records received. Do not complete this form until all records are received or classified as unobtainable as indicated on the Medical Record Shipping Form.*

## A. GENERAL INFORMATION

1. Was the event (*choose one*):  **HFF1**  
 1= In hospital only      2= Emergency Dept. visit only (ED)      3= Both ED and in hospital

2. Date of admission: (mm/dd/yyyy) / /  **HFF2**

3. Date of discharge: (mm/dd/yyyy) / /  **HFF3**

4. What was the primary admitting diagnosis code? . **HFF4**

5. What was the primary discharge diagnosis code? . **HFF5**

## B. HIP FRACTURE

6. Is a hip fracture confirmed? Yes  No  [*skip to 10*] **HFF6**

7. What was the fracture site? (*Mark the one that applies best*) **HFF7**  
 a.  Neck of femur (transcervical, cervical)  
 b.  Greater trochanter  
 c.  Intertrochanteric fracture  
 d.  Unspecified part of the proximal femur

8. Side of the hip fracture? (*Mark the one that applies best*) **HFF8**  
 a.  Right  
 b.  Left  
 c.  Both  
 d.  Unknown

9. Hip fracture based on: (*Mark the one category that applies best*)  
 a.  A written radiology report read by a radiologist which identifies the presence of a new, acute, or healing fracture of the proximal femur (femoral neck, intertrochanteric region, or the greater trochanter region) also documented on the discharge summary. **HFF9A**

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b.  A radiologist's report confirming a proximal femur fracture, but the hospital discharge summary does not confirm the diagnosis or is equivocal or missing. **HFF9B**

c.  All of the following: **HFF9C**

1. a hospital discharge summary listing fracture of the proximal femur, femoral neck fracture, intertrochanteric fracture, greater trochanteric fracture, or hip fracture;
2. equivocal written radiology report of the hip (i.e. "possible" or "probably" or "suspected" hip fracture; and
3. a written radiologist's report of either a bone scan, MRI, or CT scan unequivocally stating that a new hip fracture or healing hip fracture is present.

d.  A hip fracture diagnosis is documented in the discharge summary or other written report but no radiology report is available or the radiograph is not read by a radiologist. **HFF9D**

10. Was the hip fracture pathologic: a fracture resulting from bone tumors or cysts, Paget's disease, bone or joint prostheses, or surgical manipulation? Osteoporotic fracture is not considered a pathologic fracture.  
(Mark the one category that applies best) **HFF10**

Yes      No      Possibly

          

### C. OSTEOPOROSIS

11. Diagnosis of low bone mass/bone loss in this patient? (Mark the one that applies best) **HFF11**

- a.  Osteopenia      b.  Osteoporosis      c.  Not Documented

12. Documentation of DEXA scan testing results? (Mark the one that applies best) **HFF12**

- a.  T-Score of 2.5 or lower      b.  T-Score of 1.0 – 2.5      c.  Not Documented

13. Prior to admission or at discharge, was the patient on any of the following medications? (Mark all that apply)

- a. Oral bisphosphonate (Actonel, Fosamax, Boniva, Atelvia)
- b. IV bisphosphonate (Reclast, Zometa)
- c. Denosumab (Xgeva, Prolia) for bone loss
- d. Raloxifene (Evista) or Estrogen therapy for bone loss
- e. Other (Calcitonin, Teriparatide)
- f. Calcium supplementation
- g. Vitamin D supplementation

Admit	Discharge	NR
<input type="checkbox"/> <b>HFF13A1</b>	<input type="checkbox"/> <b>HFF13A2</b>	<input type="checkbox"/> <b>HFF13A3</b>
<input type="checkbox"/> <b>HFF13B1</b>	<input type="checkbox"/> <b>HFF13B2</b>	<input type="checkbox"/> <b>HFF13B3</b>
<input type="checkbox"/> <b>HFF13C1</b>	<input type="checkbox"/> <b>HFF13C2</b>	<input type="checkbox"/> <b>HFF13C3</b>
<input type="checkbox"/> <b>HFF13D1</b>	<input type="checkbox"/> <b>HFF13D2</b>	<input type="checkbox"/> <b>HFF13D3</b>
<input type="checkbox"/> <b>HFF13E1</b>	<input type="checkbox"/> <b>HFF13E2</b>	<input type="checkbox"/> <b>HFF13E3</b>
<input type="checkbox"/> <b>HFF13F1</b>	<input type="checkbox"/> <b>HFF13F2</b>	<input type="checkbox"/> <b>HFF13F3</b>
<input type="checkbox"/> <b>HFF13G1</b>	<input type="checkbox"/> <b>HFF13G2</b>	<input type="checkbox"/> <b>HFF13G3</b>

14. Did bone loss (osteopenia/osteoporosis) contribute to the confirmed hip fracture? Yes  No  NR

**HFF14**



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**B. SIGNS AND SYMPTOMS**

**I. Signs and Symptoms**

Did the patient have any of the following signs or symptoms at the time of the event and what was the duration of each before seeking acute care:

	<u>Yes</u>	<u>No</u>	<u>NR</u>	
11. New onset or increase in dyspnea?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA11
a. Duration of new or increased dyspnea .....	<input type="checkbox"/>	HRA11A		
12. New onset or increase in sputum production or volume?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA12
a. Duration of new or increased sputum production or volume.....	<input type="checkbox"/>	HRA12A		
13. New onset or increase in sputum purulence?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA13
a. Duration of new or increased sputum purulence.....	<input type="checkbox"/>	HRA13A		
14. New onset or increase in wheezing? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA14
a. Duration of new or increased wheezing .....	<input type="checkbox"/>	HRA14A		
15. New onset or increase in cough?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA15
a. Duration of new or increased cough.....	<input type="checkbox"/>	HRA15A		
16. New onset or increase in sore throat? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA16
a. Duration of new or increased sore throat .....	<input type="checkbox"/>	HRA16A		
17. New onset or increase of fever? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA17
a. Duration of new or increased fever .....	<input type="checkbox"/>	HRA17A		
18. New onset or increase in use of rescue bronchodilator?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA18
a. Duration of new or increased bronchodilator.....	<input type="checkbox"/>	HRA18A		
19. New onset or increase in chest tightness or chest pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA19
a. Duration of new or increased chest tightness or pain.....	<input type="checkbox"/>	HRA19A		
20. New onset or increase in leg edema (unilateral or bilateral)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA20
a. Duration of new or increased leg edema.....	<input type="checkbox"/>	HRA20A		
20b. New onset or increase in nasal discharge? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HRA20B
20.b.1. Duration of new or increased nasal discharge .....	<input type="checkbox"/>	HRA20B1		



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## II. Evidence in Physicians' Notes of Reason for Event

- |   | <u>Yes</u>               | <u>No/NR</u>   |
|---|--------------------------|--|
| 21. Was there evidence in the doctor's notes that the reason for this event may be an exacerbation of COPD, chronic bronchitis, or emphysema? ..... | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA21</span> |
| 22. Was there evidence in the doctor's notes that the reason for this event may be an exacerbation of asthma? .....                                 | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA22</span> |
| 23. Was there evidence in the doctor's notes that the reason for this event may be pneumonia? .....   | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA23</span> |
| 24. Did the patient have new onset or progressive signs/symptoms of any of these conditions after presentation to the ED or hospital? .....         | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA24</span> |

## C. MEDICAL HISTORY

- |  | <u>Yes</u>               | <u>No/NR</u>  |
|--|--------------------------|---|
| 25. Prior to this event was there a history of any of the following: |                          |   |
| a. Asthma .....  | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25A</span> |
| b. Chronic bronchitis.....   | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25B</span> |
| c. Emphysema .....   | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25C</span> |
| d. Chronic obstructive pulmonary disease (COPD).....                 | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25D</span> |
| e. Pulmonary fibrosis .....  | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25E</span> |
| f. Sarcoidosis.....  | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25F</span> |
| g. Lung cancer.....  | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25G</span> |
| h. Lung resection or lobectomy .....                                 | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25H</span> |
| i. Lung transplant.....  | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25I</span> |
| j. Home oxygen (do not include CPAP) .....                           | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25J</span> |
| k. Pulmonary embolus.....  | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25K</span> |
| l. Pulmonary hypertension.....                                       | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25L</span> |
| m. Cor pulmonale .....   | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25M</span> |
| n. Obstructive Sleep Apnea (OSA).....                                | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25N</span> |
| o. Coronary artery disease .....                                     | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25O</span> |
| p. Heart failure .....   | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25P</span> |
| q. Atrial fibrillation/atrial flutter .....                          | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25Q</span> |
| r. Diabetes .....  | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25R</span> |
| s. Pulmonary Tuberculosis.....                                       | <input type="checkbox"/> | <input type="checkbox"/> <span style="border: 1px solid red; padding: 2px;">HRA25S</span> |



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- Single Right.....1
- Single Left.....2
- Bilateral.....3

**E. PHYSICAL EXAM**

29. Vital Signs at arrival to hospital or ED (or at onset of event if began after arrival)

- a. Heart rate..... bpm **HRA29A**
- b. Respiration rate ..... per minute **HRA29B**
- c. Oxygen Saturation (SpO<sub>2</sub>/pulse oximetry) ......% **HRA29C**

1. Oxygen Sats on room air? **HRA29C1** Yes  **Skip to 29d** No  NR  **Skip to 29d**

2. If not on room air, what level oxygen? ..... **HRA29C2**  1 = Liters 2 = Percent **HRA29C2A**

d. Weight..... **HRA29D**  1 = Lbs 2 = Kg **HRA29D1**

30. Did the patient have any of the following signs (at the time of the event)?

	<u>Yes</u>	<u>No</u>	<u>NR</u>
a. Use of accessory muscles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30A</b>
b. Cyanosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30B</b>
c. Clubbing .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30C</b>
d. Jugular venous distention (JVD) or distended neck veins.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30D</b>
e. Crackles / rales.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30E</b>
f. Wheezing or rhonchi .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30F</b>
g. Decreased <u>unilateral</u> breath sounds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30G</b>
h. Decreased <u>bilateral</u> breath sounds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30H</b>
i. Prolonged expiratory time .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30I</b>
j. Egophony .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30J</b>
k. Lower extremity edema (unilateral or bilateral) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>HRA30K</b>

**F. DIAGNOSTIC TESTS**

31. Was a chest X-ray performed during this event? Yes  No/NR  **Skip to 33** **HRA31**

32. Did the patient have any of the following signs on chest x-ray at any time during this event?

- a. Hyperinflation ..... **HRA32A**
- b. Flattened diaphragms ..... **HRA32B**
- c. Consolidation or infiltrate..... **HRA32C**

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- d. Scarring .....
- e. Nodule(s) > 8mm .....
- f. Mass(es) > 3cm .....

- HRA32D**
- HRA32E**
- HRA32F**

Yes

No/NR

- g. Pulmonary edema, pulmonary vascular congestion (alveolar, interstitial) .
- h. Bilateral pleural effusion.....
- i. Unilateral pleural effusion.....
- j. Emphysema .....
- k. Cardiomegaly .....

- HRA32G**
- HRA32H**
- HRA32I**
- HRA32J**
- HRA32K**

33. Was a chest CT scan or CT angiogram (CTA) performed during this event? Yes  No/NR  **Skip to 35**

**HRA33**

34. Did the patient have any of the following signs on CT scan at any time during this event?

Yes

No/NR

- a. Emphysema .....
- b. Nodule(s) > 8mm .....
- c. Mass(es) > 3cm .....
- d. Lymphadenopathy .....
- e. Ground glass changes .....
- f. Pneumonia .....
- g. Fibrosis or honeycombing .....
- h. Filling defect—vascular (PE) .....
- i. Filling defect—mucus plug .....
- j. Cysts or blebs .....
- k. Atelectasis .....
- l. Calcifications .....
- m. Pulmonary embolus .....
- n. Enlarged pulmonary artery .....
- o. Bronchiectasis .....
- p. Pulmonary edema or pulmonary vascular congestion .....
- q. Cardiomegaly .....
- r. Bilateral pleural effusion .....
- s. Unilateral pleural effusion .....
- t. Airway wall thickening .....

- HRA34A**
- HRA34B**
- HRA34C**
- HRA34D**
- HRA34E**
- HRA34F**
- HRA34G**
- HRA34H**
- HRA34I**
- HRA34J**
- HRA34K**
- HRA34L**
- HRA34M**
- HRA34N**
- HRA34O**
- HRA34P**
- HRA34Q**
- HRA34R**
- HRA34S**
- HRA34T**

35. Was spirometry (lung function testing) performed during this hospitalization?

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Yes

No/NR  **Skip to 36** **HRA35**

a1. FEV<sub>1</sub>   .   L **HRA35A1**

% **HRA35A2**

b1. FVC   .   L **HRA35B1**

a2. FEV<sub>1</sub> Percent Predicted

b2. FVC Percent Predicted    % **HRA35B2**

c1. FEV<sub>1</sub>/FVC ratio    .   **HRA35C1**

c2. units  1 = proportion or decimal **HRA35C2**  
2 = percent (If percent, then assure not percent predicted for the ratio)

36. Was post-bronchodilator spirometry measured? Yes

No/NR  **Skip to 37** **HRA36**

a1. FEV<sub>1</sub>   .   L **HRA36A1**

a2. FEV<sub>1</sub> Percent Predicted    % **HRA36A2**

b1. FVC   .   L **HRA36B1**

b2. FVC Percent Predicted    % **HRA36B2**

c1. FEV<sub>1</sub>/FVC ratio    .   **HRA36C1**

units  1 = proportion or decimal **HRA36C2**  
2 = percent (If percent, then assure not percent predicted for the ratio)

37. Was peak expiratory flow rate (PEFR or PEF) obtained at the time of event? **HRA37**

Yes

No/NR  **Skip to 38**

a. Date of first PEF(R) taken at time of event: (mm/dd/yyyy)   /   /     **HRA37A**

b. First PEF recording    **HRA37B**

c. Worst or lowest PEF recording (anytime during hospitalization)    **HRA37C**

38. Was peak expiratory flow rate (PEFR or PEF) obtained at discharge? **HRA38**

Yes

No/NR  **Skip to 39**

a. Date of last PEF(R) taken at discharge: (mm/dd/yyyy)   /   /     **HRA38A**

b. Last PEF recording    **HRA38B**

39. Was a ventilation perfusion scan (VQ Scan) done? Yes

No/NR  **Skip to 40** **HRA39**

a. Ventilation perfusion scan results (record number of answer)

1. High probability

2. Intermediate probability

3. Low probability

4. No evidence of Pulmonary Embolus

5. Indeterminate

6. Not Recorded

**HRA39A**

40. Was an echocardiogram (TTE or TEE) performed? Yes

No/NR  **Skip to 41** **HRA40**

If more than one ECHO performed, then use the worst value for each question



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O<sub>2</sub> Saturation a4.     % **HRA50A4** b4.     % **HRA50B4**

c. First blood gas on room air? Yes  **Skip to 51** No  NR  **Skip to 51** **HRA50C**

1. If not on room air, what level oxygen?     **HRA50C1**  1 = Liters 2 = Percent **HRA50C1A**

51. Was a sputum culture done? Yes  No/NR  **Skip to 52** **HRA51**

a. Culture Results Pos  Neg  **Skip to 52** Not Recorded  **Skip to 52** **HRA51A**

b. If positive, were any of the following reported in the sputum culture? Yes No NR

1. Haemophilus Influenzae.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B1</b>
2. Moraxella Catarrhalis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B2</b>
3. Streptococcus pneumoniae.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B3</b>
4. Methicillin-resistant Staphylococcus Aureus (MRSA) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B4</b>
5. Staphylococcus aureus (not MRSA) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B5</b>
6. Mycoplasma pneumoniae .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B6</b>
7. Pseudomonas Aureginosa .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B7</b>
8. Chlamydomphila (or Chlamydia) pneumoniae .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B8</b>
9. Oropharyngeal flora .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B9</b>
10. Klebsiella pneumoniae .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B10</b>
11. Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA51B11</b>

Specify **HRA51B11A**

52. Was a bronchoscopy culture done? Yes  No/NR  **Skip to 53** **HRA52**

a. Culture Results Pos  Neg  **Skip to 53** Not Recorded  **Skip to 53** **HRA52A**

b. If positive, were any of the following reported in the bronchoscopy culture? Yes No NR

1. Haemophilus Influenzae.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B1</b>
2. Moraxella Catarrhalis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B2</b>
3. Streptococcus pneumoniae.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B3</b>
4. Methicillin-resistant Staphylococcus Aureus (MRSA) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B4</b>
5. Staphylococcus aureus (not MRSA) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B5</b>
6. Mycoplasma pneumoniae .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B6</b>
7. Pseudomonas Aureginosa .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B7</b>
8. Chlamydomphila (or Chlamydia) pneumoniae .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B8</b>
9. Oropharyngeal flora .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HRA52B9</b>

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10. *Klebsiella pneumoniae* .....    **HRA52B10**
11. Other .....    **HRA52B11**

Specify **HRA52B11A**

53. Was a blood culture done?      Yes         No/NR         **Skip to 54**      **HRA53**

a. Culture Results      Pos         Neg         **Skip to 54**      Not Recorded         **Skip to 54**      **HRA53A**

b. If positive, were any of the following reported in the blood culture?      Yes      No      NR

1. *Haemophilus Influenzae*.....              **HRA53B1**
2. *Moraxella Catarrhalis* .....              **HRA53B2**
3. *Streptococcus pneumoniae*.....              **HRA53B3**
4. Methicillin-resistant *Staphylococcus Aureus* (MRSA) .....              **HRA53B4**
5. *Staphylococcus aureus* (not MRSA) .....              **HRA53B5**
6. Other \_\_\_\_\_ **HRA53B6**      **HRA53B6A**

54. Influenza swab      Pos         Neg         Not Recorded         **HRA54**

**H. TREATMENTS / MEDICATIONS**

- |  | <u>Yes</u>               | <u>No/NR</u>                          |
|--|--------------------------|---------------------------------------|
| 55. CPAP or BiPAP (non-invasive mechanical ventilation).....                   | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA55</b> |
| 56. Invasive Mechanical Ventilation.....                                       | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA56</b> |
| 57. Inhaled short-acting beta-agonists (ie,albuterol, xopenex) .....           | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA57</b> |
| 58. Inhaled short-acting anticholinergics (ie, atrovent, ipratropium) .....    | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA58</b> |
| 59. Inhaled long-acting anticholinergics (ie, spiriva, tudorza pressair) ..... | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA59</b> |
| 60. Inhaled long-acting beta-agonists (ie: serevent) .....                     | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA60</b> |
| 61. Inhaled Corticosteroid for respiratory event.....                          | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA61</b> |
| 62. Oxygen (continuous or prn) .....   | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA62</b> |
| 63. Antibiotics for respiratory event (IV or PO) .....                         | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA63</b> |
| 64. Systemic Corticosteroid for respiratory event (IV or PO).....              | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA64</b> |
| 65. IV Lasix or Furosemide.....  | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA65</b> |
| 66. Leukotriene antagonist (ie. singulair, accolate).....                      | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA66</b> |
| 67. Home oxygen.....   | <input type="checkbox"/> | <input type="checkbox"/> <b>HRA67</b> |







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"I'm sorry for your loss. We understand that you might be able to help us complete our documents for (decedent), particularly the circumstances surrounding (his/her) death. Is now a good time to talk?" **IF10J**

No answer **IF10J1**

- First attempt
- Second attempt
- Third attempt
- Fourth attempt
- Fifth attempt

No —————> When would be convenient to call back? **IF10J2** \_\_\_\_\_

No —————> Do not contact again **Skip to 19**

Yes —————> Thank you. If you have any questions, please ask me.

1. Before we get started could you please tell me what was your relationship with (insert name of decedent)? (Respondent was deceased's...) **IF11**

- Spouse
- Daughter/Son
- Parent
- Friend
- Workmate
- Other relative
- Other

Specify relationship of other: **IF11A** \_\_\_\_\_

**A. CIRCUMSTANCES SURROUNDING DEATH**

"I'd like to ask you a few questions about (decedent's name)'s medical history and the events leading up to (his/her) death."

2. Please tell me about his/her general health, health on the day s/he died, and about the death itself.

Record a brief synopsis of the events surrounding the death as related by the informant:

**Removed from Blinded Dataset**

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“Some of the remaining questions may repeat information you already provided, but it helps us to ask these items specifically.”

3. How long was it between the time (*decedent's name*) was last known to be alive and the time (*he/she*) was found dead? **IFI3**

- Less than 5 minutes
- 5 minutes to 1 hour
- 1 to 24 hours
- Longer than 24 hours
- Unknown

4. Please tell me who was present. (Mark all that apply.)

- |                       |    |                          |     |                          |                       |              |
|-----------------------|----|--------------------------|-----|--------------------------|-----------------------|--------------|
| Self                  | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> | <b>Skip to Item 6</b> | <b>IFI4A</b> |
| Health care person(s) | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> | <b>IFI4B</b>          |              |
| Other person(s)       | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> | <b>IFI4C</b>          |              |

5. When was the last time you saw (*decedent's name*) prior to (*his/her*) death? **IFI5**

- Less than 5 minutes
- 5 minutes to 1 hour
- 1 to 24 hours
- Longer than 24 hours
- Unknown

## B. MEDICAL HISTORY

“I’d now like to ask you a few questions about (*decedent's name*) medical history.”

6. Was (*he/she*) hospitalized within the four weeks prior to death? **IFI6**

- |         |                          |                        |
|---------|--------------------------|------------------------|
| No      | <input type="checkbox"/> | <b>Skip to Item 10</b> |
| Yes     | <input type="checkbox"/> |                        |
| Unknown | <input type="checkbox"/> | <b>Skip to Item 10</b> |

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7. What was the reason for the hospitalization? (Select all that apply.)

- a. Unknown Yes  No  **IFI7A**
- b. Respiratory Yes  No  **IFI7B**
- b1. Emphysema, Chronic Bronchitis, or chronic obstructive pulmonary disease (COPD) Yes  No  **IFI7B1**
- b2. Pneumonia Yes  No  **IFI7B2**
- b3. Other respiratory Yes  No  **IFI7B3**
- c. Cardiac Yes  No  **IFI7C**
- c1. Heart Attack Yes  No  **IFI7C1**
- c2. Heart Failure Yes  No  **IFI7C2**
- c3. Other heart problem Yes  No  **IFI7C3**
- Specify: **IFI7C3A**
- d. Cancer Yes  No  **IFI7D**
- d1. Lung Yes  No  **IFI7D1**
- d2. Other cancer Yes  No  **IFI7D2** **IFI7D2A**
- e. Other condition Yes  No  **IFI7E**
- Specify: **IFI7E1**

8. What was the date of the hospitalization?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

**IFI8**

9. What was the name and location of the hospital?

**Removed from Blinded Dataset**

10. Was (insert decedent's name) seen by a doctor any other time in the last four weeks prior to death?

**IFI10**

- No  **Skip to Item 12**
- Yes
- Unknown  **Skip to Item 12**

11. What was the name and address of this doctor?

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### C. SYMPTOMS

“Now I’d like to talk about specific symptoms (*decedent’s name*) might have experienced just prior to (*his/her*) death.”

12. Did (*he/she*) experience an increase in shortness of breath? **IFI12**

- No   
Yes   
Unknown

13. Did (*he/she*) experience increased coughing? **IFI13**

- No   
Yes   
Unknown

14. Did (*he/she*) experience increased mucus or sputum production? **IFI14**

- No   
Yes   
Unknown

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#### D. EMERGENCY MEDICAL CARE

"I now have a few questions about emergency medical care (*insert decedent's name*) may have received prior to or at the time of death. You may have already given this information in an answer to an earlier question, and I apologize if these questions seem repetitive, but it is important to obtain information specifically on emergency medical care."

15. Was a physician, ambulance or other emergency medical team called? **IFI15**

- No  **Skip to Item 16**
- Yes
- Unknown  **Skip to Item 16**

15a. How long was it from the time the last episode of symptoms started to the time that medical assistance was called for? **IFI15A**

- 5 minutes or less
- 10 minutes or less
- 1 hour or less
- 6 hours or less
- 24 hours or less
- More than 24 hours
- Unknown

16. Were resuscitation measures, such as CPR attempted? **IFI16**

- No
- Yes
- Unknown

17. Was (*decedent's name*) taken to the hospital, emergency room or any other emergency care facility? **IFI17**

- No
- Yes
- Unknown

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### E. CAUSE OF DEATH

18. To the best of your knowledge, what was the reason for the death? (Select all that apply.)

- |  |     |                          |    |                          |                                |
|--|-----|--------------------------|----|--------------------------|--------------------------------|
| a. Unknown   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18A</b>                  |
| b. Respiratory   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18B</b>                  |
| b1. Emphysema, Chronic Bronchitis,<br>or chronic obstructive pulmonary<br>disease (COPD) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18B1</b>                 |
| b2. Pneumonia  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18B2</b>                 |
| b3. Other respiratory cause  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18B3</b>                 |
| c. Cardiac   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18C</b>                  |
| c1. Heart Attack   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18C1</b>                 |
| c2. Heart Failure  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18C2</b>                 |
| c3. Other heart problem  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18C3</b>                 |
| Specify: <u>    <b>IFI18C3A</b>    </u>  |     |                          |    |                          |                                |
| d. Cancer  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18D</b>                  |
| d1. Lung   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18D1</b>                 |
| d2. Other  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18D2</b> <b>IFI18D2A</b> |
| e. Other condition   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | <b>IFI18E</b>                  |
| Specify: <u>    <b>IFI18E1</b>    </u>   |     |                          |    |                          |                                |

### F. ADDITIONAL INFORMANTS

19. Is there anyone else we could contact who might be able to provide additional information about the circumstances surrounding (*decedent's name*) death or (*his/her*) usual state of health? **IFI19**

- No  **Skip to Closing Script**
- Yes
- Unknown  **Skip to Closing Script**



ID NUMBER:									
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20. How is (*he/she*) related to (*decedent's name*)? **IFI20**

- Spouse
- Daughter/Son
- Parent
- Friend
- Workmate
- Other relative
- Other

Specify relationship of other: **IFI20A** \_\_\_\_\_

21. What is the name and address of this person?

**Removed from Blinded Dataset**

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### G. CLOSING SCRIPT

“Thank you very much for your assistance in this study. This information is very important for advancing our understanding of lung disease. Do you have any questions? Thanks again for your help.”

### H. RELIABILITY (To be completed after the interview)

22. On the basis of these questions, give your rating of reliability of the interview. **IFI22**

- Poor
- Fair
- Good

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### I. COORDINATOR SUMMARY

23. Please provide a narrative summary of the conversation with the informant, describing any pertinent details that may not have been captured by this form that will aid the adjudication committee in determining any circumstances and underlying conditions that may have contributed to a subject's death in addition to determining the ultimate cause of death.

Removed from Blinded Dataset

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ID NUMBER:									
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FORM CODE: **ISP**  
 VERSION: 2.0 6/12/13

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8)	Spirometry ok to continue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>ISP08</b>
9)	10 min post albuterol trial #1	a) <b>ISP09A</b>
10)	trial #2	a) <b>ISP10A</b>
11)	trial #3	a) <b>ISP11A</b>
12)	1 min at 0.9% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP12A</b>
13)	2 min at 0.9% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP13A</b>
14)	5 min at 0.9% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP14A</b>
15)	7 min at 0.9% NaCl	a) <b>ISP15A</b>
16)	First 7 minutes complete, continue induction?	<input type="checkbox"/> Yes <input type="checkbox"/> No → <b>Go to Item 27</b> <b>ISP16</b>
17)	If yes, % NaCl used:  NOTE: If FEV <sub>1</sub> <10% drop, then increase to 3% NaCl after sample collected. If FEV <sub>1</sub> =11-19% then continue at .9% NaCl. If FEV <sub>1</sub> >20% drop, then stop induction procedure.	<input type="checkbox"/> 0.9% NaCL <input type="checkbox"/> 3% NaCL <b>ISP17</b>
18)	1 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP18A</b>
19)	2 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP19A</b>
20)	5 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP20A</b>
21)	7 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP21A</b>
22)	Second 7 minutes complete, continue induction?  NOTE: if continuing, use same saline concentration	<input type="checkbox"/> Yes <input type="checkbox"/> No → <b>Go to Item 27</b> <b>ISP22</b>
23)	1 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP23A</b>
24)	2 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP24A</b>

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25)	5 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP25A</b>
26)	7 min Third 7 minutes complete. Induction Complete.	a) <b>ISP26A</b>

Remind subject to rinse mouth and cheeks thoroughly, gargle - spit into sink.  
 Clear throat, scraping throat and roof of mouth - spit into sink. Blow nose – discard  
 Deep cough from chest and spit into sputum sample cup.  
**DO NOT HOCK OR SCRAPE** when producing sample. Passively bring it past the throat into the cup!

27) Was the participant able to produce sputum? .....  **ISP27**  
 Yes.....Y  
 No .....N

28) Was the induction terminated early? .....  **ISP28**  
 Yes.....Y  
 No .....N → **Go to End**

29) Reason terminated early .....  **ISP29**  
 FEV<sub>1</sub> dropped >20% .....1  
 Participant requested to stop .....2  
 Other .....3  
 Specify Other: **ISP29A** \_\_\_\_\_

30) Did the participant require additional albuterol? .....  **ISP30**  
 Yes.....Y  
 No .....N → **Go to Item 33**

If participant's FEV<sub>1</sub> dropped >20% from baseline and/or if a 2<sup>nd</sup> dose of albuterol was required, conduct a post-induction spirometry and record values here:

FEV <sub>1</sub>		
31)	Trial #1	<b>ISP31A</b>
32)	Trial #2	<b>ISP36A</b>
33)	Trial #3	<b>ISP33A</b>

34) Note reason and time point obtained: **ISP34**  
 \_\_\_\_\_  
 \_\_\_\_\_



## INDUCED SPUTUM WORKSHEET

**For post albuterol FEV<sub>1</sub> <50% Predicted**

ID NUMBER: BLINDID

FORM CODE: **ISP**  
VERSION: 1.0 10/26/10

Visit VISIT SEQ #

0a) Form Date: .....   /   /     ISP0A      0b) Initials .....    ISP0B

**Instructions:** This form should be completed during the participant's visit. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box.

1) 10% fall from ISP01A   .   is ISP01B   .   - use this value to determine if saline is to be increased to 3% after the first 7 min. (use best post albuterol FEV<sub>1</sub> to calculate)

2) 20% fall from ISP02A   .   is ISP02B   .   (use best post albuterol FEV<sub>1</sub>)  
(Discontinue tests, give albuterol. Perform PFTs at 10 minutes)

3) Was the participant given albuterol prior to sputum induction? .....  ISP03  
Yes ..... Y  
No ..... N

3a) Was this a re-dosing (e.g., >165 minutes after initial bronchodilator dose for PFTs)?  ISP03A  
Yes ..... Y  
No ..... N

3b) How many puffs of albuterol was the participant given? .....  ISP03B

FEV<sub>1</sub>

4)	Baseline #1	a) <span style="border: 1px solid red; padding: 2px;">ISP04A</span>
5)	Baseline #2	a) <span style="border: 1px solid red; padding: 2px;">ISP05A</span>
6)	Baseline #3	a) <span style="border: 1px solid red; padding: 2px;">ISP06A</span>
7)	Baseline spirometry reviewed by: <span style="border: 1px solid red; padding: 2px;">Variable Removed</span>	
8)	Spirometry ok to continue? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="border: 1px solid red; padding: 2px;">ISP08</span>	
9)	10 min post albuterol trial #1	a) <span style="border: 1px solid red; padding: 2px;">ISP09A</span>
10)	trial #2	a) <span style="border: 1px solid red; padding: 2px;">ISP10A</span>
11)	trial #3	a) <span style="border: 1px solid red; padding: 2px;">ISP11A</span>

ID NUMBER:									
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FORM CODE: **ISP**  
 VERSION: 1.0 10/26/10

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12)	1 min at 0.9% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP12A</b>
13)	2 min at 0.9% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP13A</b>
14)	5 min at 0.9% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP14A</b>
15)	7 min at 0.9% NaCl	a) <b>ISP15A</b>
16)	First 7 minutes complete, continue induction?	<input type="checkbox"/> Yes <input type="checkbox"/> No → <b>Go to Item 27</b> <b>ISP16</b>
17)	If yes, % NaCl used:  NOTE: If FEV <sub>1</sub> <10% drop, then increase to 3% NaCl after sample collected. If FEV <sub>1</sub> =11-19% then continue at .9% NaCl. If FEV <sub>1</sub> >20% drop, then stop induction procedure.	<input type="checkbox"/> 0.9% NaCl <input type="checkbox"/> 3% NaCl <b>ISP17</b>
18)	1 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP18A</b>
19)	2 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP19A</b>
20)	5 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP20A</b>
21)	7 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP21A</b>
22)	Second 7 minutes complete, continue induction?  NOTE: if continuing, use same saline concentration	<input type="checkbox"/> Yes <input type="checkbox"/> No → <b>Go to Item 27</b> <b>ISP22</b>
23)	1 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP23A</b>
24)	2 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP24A</b>
25)	5 min If FEV <sub>1</sub> <20% drop, continue	a) <b>ISP25A</b>
26)	7 min  Third 7 minutes complete. Induction Complete.	a) <b>ISP26A</b>

ID NUMBER:									
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FORM CODE: **ISP**  
 VERSION: 1.0 10/26/10

Visit  
 Number

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SEQ #

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Remind subject to rinse mouth and cheeks thoroughly, gargle - spit into sink.  
 Clear throat, scraping throat and roof of mouth - spit into sink. Blow nose – discard  
 Deep cough from chest and spit into sputum sample cup.  
**DO NOT HOCK OR SCRAPE** when producing sample. Passively bring it past the throat into the cup!

27) Was the participant able to produce sputum? .....  **ISP27**  
 Yes.....Y  
 No .....N

28) Was the induction terminated early? .....  **ISP28**  
 Yes.....Y  
 No .....N → **Go to End**

29) Reason terminated early .....  **ISP29**  
 FEV1 dropped >20% .....1  
 Participant requested to stop .....2  
 Other .....3  
 Specify Other: **ISP29A** \_\_\_\_\_

30) Did the participant require additional albuterol? .....  **ISP30**  
 Yes.....Y  
 No .....N → **Go to Item 33**

If participant's FEV1 dropped >20% from baseline and/or if a 2<sup>nd</sup> dose of albuterol was required, conduct a post-induction spirometry and record values here:

FEV <sub>1</sub>		
31)	Trial #1	<b>ISP31A</b>
32)	Trial #2	<b>ISP36A</b>
33)	Trial #3	<b>ISP33A</b>

34) Note reason and time point obtained: **ISP34**  
 \_\_\_\_\_  
 \_\_\_\_\_





## INDUCED SPUTUM WORKSHEET

For post albuterol FEV<sub>1</sub> >50% Predicted

ID NUMBER:

FORM CODE: ISW  
VERSION: 2.0 6/12/13

Visit Number  SEQ #

0a) Form Date: .....   /   /           0b) Initials.....

0c) Date Collected:....   /   /

0d) Time Collected: ...    AM/PM (circle one)

**Instructions:** This form should be completed during the participant's visit. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box.

- 1) 10% fall from    is    - Continue at present concentration – do not increase saline concentration (use best post albuterol FEV<sub>1</sub> to calculate)
  
- 2) 20% fall from    is    (use best post albuterol FEV<sub>1</sub>)  
(Discontinue tests, give albuterol. Perform PFTs at 10 minutes post administration)
  
- 3) Was the participant given albuterol prior to sputum induction? ..... 
  - Yes.....Y
  - No .....N
  
- 3a) Was this a re-dosing (e.g., >165 minutes after initial bronchodilator dose for PFTs)? 
  - Yes.....Y
  - No .....N
  
- 3b) How many puffs of albuterol was the participant given? .....

		FEV <sub>1</sub>
4)	Baseline #1	a) <input style="border: 1px solid red; padding: 2px;" type="text" value="ISW04A"/>
5)	Baseline #2	a) <input style="border: 1px solid red; padding: 2px;" type="text" value="ISW05A"/>
6)	Baseline #3	a) <input style="border: 1px solid red; padding: 2px;" type="text" value="ISW06A"/>
7)	Baseline spirometry reviewed by:	Removed from Blinded Dataset
8)	Spirometry ok to continue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input style="border: 1px solid red; padding: 2px;" type="text" value="ISW08"/>

ID NUMBER:									
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FORM CODE: **ISW**  
 VERSION: **2.0** 6/12/13

Visit Number		
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SEQ #			
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9)	10 min post albuterol trial #1	a) <b>ISW09A</b>
10)	trial #2	a) <b>ISW10A</b>
11)	trial #3	a) <b>ISW11A</b>
12)	2 min at 3% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISW12A</b>
13)	7 min at 3% NaCl	a) <b>ISW13A</b>
14)	First 7 minutes complete, continue induction?	<input type="checkbox"/> Yes <input type="checkbox"/> No → <b>Go to Item 22</b> <b>ISW14</b>
15)	If yes, % NaCl used: NOTE: If FEV <sub>1</sub> <10% drop, then increase to 4% NaCl after sample collected. If FEV <sub>1</sub> =11-19% then continue at 3% NaCl. If FEV <sub>1</sub> >20% drop, then stop induction procedure.	<input type="checkbox"/> 3% NaCl <input type="checkbox"/> 4% NaCl <b>ISW15</b>
16)	2 min at 4% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISW16A</b>
17)	7 min at 4% NaCl	a) <b>ISW17A</b>
18)	Second 7 minutes complete, continue induction?	<input type="checkbox"/> Yes <input type="checkbox"/> No → <b>Go to Item 22</b> <b>ISW18</b>
19)	If yes, % NaCl used: NOTE: If you did not increase % NaCl in step 15, then continue at 3% unless FEV <sub>1</sub> >20% drop. If you did increase NaCl to 4% and FEV <sub>1</sub> <10% drop, then increase to 5%. If FEV <sub>1</sub> =11-19% then continue at 4% NaCl. If FEV <sub>1</sub> >20% drop, then stop induction procedure.	<input type="checkbox"/> 3% NaCl <input type="checkbox"/> 4% NaCl <input type="checkbox"/> 5% NaCl <b>ISW19</b>
20)	2 min at 5% NaCl If FEV <sub>1</sub> <20% drop, continue	a) <b>ISW20A</b>
21)	7 min at 5% NaCl Induction complete.	a) <b>ISW21A</b>

Remind subject to rinse mouth and cheeks thoroughly, gargle - spit into sink.  
 Clear throat, scraping throat and roof of mouth - spit into sink. Blow nose – discard  
 Induced Sputum Worksheet, ISW

ID NUMBER:									
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SEQ # 

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Deep cough from chest and spit into sputum sample cup.  
DO NOT HOCK OR SCRAPE when producing sample. Passively bring it past the throat into the cup!

22) Was the participant able to produce sputum? .....  ISW22  
Yes.....Y  
No .....N

23) Was the induction terminated early? .....  ISW23  
Yes.....Y  
No .....N → Go to 25

24) Reason terminated early .....  ISW24  
FEV1 dropped >20% .....1  
Participant requested to stop .....2  
Other .....3

Specify Other: ISW24A \_\_\_\_\_

25) Did the participant require additional albuterol? .....  ISW25  
Yes.....Y  
No .....N → Go to End

If participant's FEV1 dropped >20% from baseline and/or if a 2<sup>nd</sup> dose of albuterol was required, conduct a post-induction spirometry and record values here:

FEV<sub>1</sub>

26)	Trial #1	ISW26A
27)	Trial #2	ISW27A
28)	Trial #3	ISW28A

29) Note reason and time point obtained: ISW29

\_\_\_\_\_  
\_\_\_\_\_



## INDUCED SPUTUM WORKSHEET

For post albuterol FEV<sub>1</sub> >50% Predicted

ID NUMBER: BLINDID

FORM CODE: ISW  
VERSION: 1.0 10/26/10

Visit VISIT SEQ #

0a) Form Date:.....   /   /     ISW0A    0b) Initials .....    ISW0B

**Instructions:** This form should be completed during the participant's visit. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box.

1) 10% fall from ISW01A   .   is ISW01B   .   - Continue at present concentration – do not increase saline concentration (use best post albuterol FEV<sub>1</sub> to calculate)

2) 20% fall from ISW02A   .   is ISW02B   .   (use best post albuterol FEV<sub>1</sub>)  
(Discontinue tests, give albuterol. Perform PFTs at 10 minutes post administration)

3) Was the participant given albuterol prior to sputum induction?.....  ISW03  
 Yes ..... Y  
 No ..... N

3a) Was this a re-dosing (e.g., >165 minutes after initial bronchodilator dose for PFTs)?  ISW03A  
 Yes ..... Y  
 No ..... N

3b) How many puffs of albuterol was the participant given? .....  ISW03B

FEV<sub>1</sub>

4)	Baseline #1	a) <span style="border: 1px solid red; padding: 2px;">ISW04A</span>
5)	Baseline #2	a) <span style="border: 1px solid red; padding: 2px;">ISW05A</span>
6)	Baseline #3	a) <span style="border: 1px solid red; padding: 2px;">ISW06A</span>
7)	Baseline spirometry reviewed by: <span style="border: 1px solid red; padding: 2px;">Variable Removed</span>	
8)	Spirometry ok to continue? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="border: 1px solid red; padding: 2px;">ISW08</span>	
9)	10 min post albuterol trial #1	a) <span style="border: 1px solid red; padding: 2px;">ISW09A</span>
10)	trial #2	a) <span style="border: 1px solid red; padding: 2px;">ISW10A</span>
11)	trial #3	a) <span style="border: 1px solid red; padding: 2px;">ISW11A</span>

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FORM CODE: ISW  
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12)	2 min at 3% NaCl If FEV <sub>1</sub> <20% drop, continue	a) ISW12A
13)	7 min at 3% NaCl	a) ISW13A
14)	First 7 minutes complete, continue induction?	<input type="checkbox"/> Yes <input type="checkbox"/> No → Go to Item 20 ISW14
15)	If yes, % NaCl used: NOTE: If FEV <sub>1</sub> <10% drop, then increase to 4% NaCl after sample collected. If FEV <sub>1</sub> =11-19% then continue at 3% NaCl. If FEV <sub>1</sub> >20% drop, then stop induction procedure.	<input type="checkbox"/> 3% NaCl <input type="checkbox"/> 4% NaCl ISW15
16)	2 min at 4% NaCl If FEV <sub>1</sub> <20% drop, continue	a) ISW16A
17)	7 min at 4% NaCl	a) ISW17A
18)	Second 7 minutes complete, continue induction?	<input type="checkbox"/> Yes <input type="checkbox"/> No → Go to Item 20 ISW18
19)	If yes, % NaCl used: NOTE: If you did not increase % NaCl in step 15, then continue at 3% unless FEV <sub>1</sub> >20% drop. If you did increase NaCl to 4% and FEV <sub>1</sub> <10% drop, then increase to 5%. If FEV <sub>1</sub> =11-19% then continue at 4% NaCl. If FEV <sub>1</sub> >20% drop, then stop induction procedure.	<input type="checkbox"/> 3% NaCl <input type="checkbox"/> 4% NaCl <input type="checkbox"/> 5% NaCl ISW19
20)	2 min at 5% NaCl If FEV <sub>1</sub> <20% drop, continue	a) ISW20A
21)	7 min at 5% NaCl Induction complete.	a) ISW21A

Remind subject to rinse mouth and cheeks thoroughly, gargle - spit into sink.  
Clear throat, scraping throat and roof of mouth - spit into sink. Blow nose – discard  
Deep cough from chest and spit into sputum sample cup.  
DO NOT HOCK OR SCRAPE when producing sample. Passively bring it past the throat into the cup!

ID NUMBER:									
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FORM CODE: ISW  
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SEQ #			
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22) Was the participant able to produce sputum? .....  ISW22

Yes ..... Y  
No ..... N

23) Was the induction terminated early? .....  ISW23

Yes ..... Y  
No ..... N → **Go to 23**

24) Reason terminated early .....  ISW24

FEV1 dropped >10% ..... 1  
Participant requested to stop ..... 2  
Other ..... 3

Specify Other: ISW24A

25) Did the participant require additional albuterol? .....  ISW25

Yes ..... Y  
No ..... N → **Go to End**

If participant's FEV1 dropped >20% from baseline and/or if a 2<sup>nd</sup> dose of albuterol was required, conduct a post-induction spirometry and record values here:

FEV<sub>1</sub>

26)	Trial #1	ISW26A
27)	Trial #2	ISW27A
28)	Trial #3	ISW28A

29) Note reason and time point obtained: **ISW29**

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ID NUMBER:									
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FORM CODE: MCF  
VERSION: 1.0 06/17/13

Visit Number		
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SEQ #			
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## HOSPITALIZATIONS

2) Since your last (*clinic visit or telephone contact*) on (*date*), have you had a flare-up of your chest trouble? (Y/N).....  **MCF2**  
(if 'No' go to item 20)

If Yes:

2a) How many episodes of chest trouble flare ups have you had since (*date*)? .....  **MCF2a**

How was/were the episode(s) of breathing problem(s) treated? Please answer for each episode (if more than one) by checking all relevant treatments given for each episode. Starting with the first episode since (*date*):

3) For the first episode of breathing problems you had since (*date*):

3a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **MCF3a**

3b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **MCF3b**

3c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **MCF3c**

3d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **MCF3d**

3e) Were you evaluated in a physician's office or urgent care? (Y/N).....  **MCF3e**

During that visit were you given (check all that apply):

3e1) An additional antibiotic .....  **MCF3e1**

3e2) Additional steroids .....  **MCF3e2**

3e3) Don't know .....  **MCF3e3**

3e4) Don't remember .....  **MCF3e4**

3f) Were you evaluated in an Emergency Department? .....  **MCF3f**

During that visit were you given (check all that apply):

3f1) An additional antibiotic .....  **MCF3f1**

3f2) Additional steroids .....  **MCF3f2**

3f3) Don't know .....  **MCF3f3**

3f4) Don't remember .....  **MCF3f4**

3g) What was the date of this event? ..... // **MCF3g**

3h) What is the name of the medical facility? **Removed from Blinded Dataset**

3i) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)



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3j) For clarification of our records, under what name is this record?

3j1) First Name: Removed from Blinded Dataset

3j2) Second Name: Removed from Blinded Dataset

3j3) Last Name: Removed from Blinded Dataset

3j4) Maternal Last Name: Removed from Blinded Dataset

3k) Were you admitted to the hospital? .....  **MCF3k**

If participant was admitted to hospital:

4a) What was the date of this event? ..... // **MCF4a**

4b) What is the name of the medical facility? Removed from Blinded Dataset

4c) What is the address of this medical facility? Removed from Blinded Dataset

(Leave blank if unknown)

4d) For clarification of our records, under what name is this record?

4d1) First Name: Removed from Blinded Dataset

4d2) Second Name: Removed from Blinded Dataset

4d3) Last Name: Removed from Blinded Dataset

4d4) Maternal Last Name: Removed from Blinded Dataset

5) (do not ask) Did the participant have a second episode? (if 'No', go to 20) .....  **MCF5**

6) For the second episode of breathing problems you had since (date):

6a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **MCF6a**

6b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **MCF6b**

6c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **MCF6c**

6d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **MCF6d**

6e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **MCF6e**

During that visit were you given (check all that apply):

6e1) An additional antibiotic .....  **MCF6e1**

6e2) Additional steroids .....  **MCF6e2**

6e3) Don't know .....  **MCF6e3**

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- 6e4) Don't remember .....  MCF6e4
- 6f) Were you evaluated in an Emergency Department? .....  MCF6f
- During that visit were you given (check all that apply):
- 6f1) An additional antibiotic .....  MCF6f1
- 6f2) Additional steroids .....  MCF6f2
- 6f3) Don't know .....  MCF6f3
- 6f4) Don't remember .....  MCF6f4
- 6g) What was the date of this event? .....   /   /     MCF6g
- 6h) What is the name of the medical facility? Removed from Blinded Dataset
- 6i) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)
- 6j) For clarification of our records, under what name is this record?
- 6j1) First Name: Removed from Blinded Dataset
- 6j2) Second Name: Removed from Blinded Dataset
- 6j3) Last Name: Removed from Blinded Dataset
- 6j4) Maternal Last Name: Removed from Blinded Dataset
- 6k) Were you admitted to the hospital? .....  MCF6k
- If participant was admitted to hospital:
- 7a) What was the date of this event? .....   /   /     MCF7a
- 7b) What is the name of the medical facility? Removed from Blinded Dataset
- 7c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)
- 7d) For clarification of our records, under what name is this record?
- 7d1) First Name: Removed from Blinded Dataset
- 7d2) Second Name: Removed from Blinded Dataset
- 7d3) Last Name: Removed from Blinded Dataset
- 7d4) Maternal Last Name: Removed from Blinded Dataset
- 8) (do not ask) Did the participant have a third episode? (if 'No', go to 20) .....  MCF8
- 9) For the third episode of breathing problems you had since (date):



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10b) What is the name of the medical facility?  **Removed from Blinded Dataset**

10c) What is the address of this medical facility?  **Removed from Blinded Dataset**  
(Leave blank if unknown)

10d) For clarification of our records, under what name is this record?

10d1) First Name:  **Removed from Blinded Dataset**

10d2) Second Name:  **Removed from Blinded Dataset**

10d3) Last Name:  **Removed from Blinded Dataset**

10d4) Maternal Last Name:  **Removed from Blinded Dataset**

11) (do not ask) Did the participant have a fourth episode? (if 'No', go to 20) .....  **MCF11**

12) For the fourth episode of breathing problems you had since (date):

12a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **MCF12a**

12b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **MCF12b**

12c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **MCF12c**

12d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **MCF12d**

12e) Were you evaluated in a physician's office or urgent care? (Y/N) .....  **MCF12e**

During that visit were you given (check all that apply):

12e1) An additional antibiotic .....  **MCF12e1**

12e2) Additional steroids .....  **MCF12e2**

12e3) Don't know .....  **MCF12e3**

12e4) Don't remember .....  **MCF12e4**

12f) Were you evaluated in an Emergency Department? .....  **MCF12f**

During that visit were you given (check all that apply):

12f1) An additional antibiotic .....  **MCF12f1**

12f2) Additional steroids .....  **MCF12f2**

12f3) Don't know .....  **MCF12f3**

12f4) Don't remember .....  **MCF12f4**

12g) What was the date of this event? .....   /   /      **MCF12g**

12h) What is the name of the medical facility?  **Removed from Blinded Dataset**

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12i) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

12j) For clarification of our records, under what name is this record?

12j1) First Name: Removed from Blinded Dataset

12j2) Second Name: Removed from Blinded Dataset

12j3) Last Name: Removed from Blinded Dataset

12j4) Maternal Last Name: Removed from Blinded Dataset

12k) Were you admitted to the hospital? .....  **MCF12k**

If participant was admitted to hospital:

13a) What was the date of this event?..... // **MCF13a**

13b) What is the name of the medical facility? Removed from Blinded Dataset

13c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

13d) For clarification of our records, under what name is this record?

13d1) First Name: Removed from Blinded Dataset

13d2) Second Name: Removed from Blinded Dataset

13d3) Last Name: Removed from Blinded Dataset

13d4) Maternal Last Name: Removed from Blinded Dataset

14) (do not ask) Did the participant have a fifth episode? (if 'No', go to 20).....  **MCF14**

15) For the fifth episode of breathing problems you had since (date):

15a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **MCF15a**

15b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **MCF15b**

15c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **MCF15c**

15d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **MCF15d**

15e) Were you evaluated in a physician's office or urgent care? (Y/N).....  **MCF15e**

During that visit were you given (check all that apply):

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- 15e1) An additional antibiotic .....  MCF15e1
- 15e2) Additional steroids .....  MCF15e2
- 15e3) Don't know .....  MCF15e3
- 15e4) Don't remember .....  MCF15e4
- 15f) Were you evaluated in an Emergency Department? .....  MCF15f  
During that visit were you given (check all that apply):
  - 15f1) An additional antibiotic .....  MCF15f1
  - 15f2) Additional steroids .....  MCF15f2
  - 15f3) Don't know .....  MCF15f3
  - 15f4) Don't remember .....  MCF15f4
- 15g) What was the date of this event? .....   /   /     MCF15g
- 15h) What is the name of the medical facility? Removed from Blinded Dataset
- 15i) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)
- 15j) For clarification of our records, under what name is this record?
  - 15j1) First Name: Removed from Blinded Dataset
  - 15j2) Second Name: Removed from Blinded Dataset
  - 15j3) Last Name: Removed from Blinded Dataset
  - 15j4) Maternal Last Name: Removed from Blinded Dataset
- 15k) Were you admitted to the hospital? .....  MCF15k  
If participant was admitted to hospital:
  - 16a) What was the date of this event? .....   /   /     MCF16a
  - 16b) What is the name of the medical facility? Removed from Blinded Dataset
  - 16c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)
  - 16d) For clarification of our records, under what name is this record?
    - 16d1) First Name: Removed from Blinded Dataset
    - 16d2) Second Name: Removed from Blinded Dataset
    - 16d3) Last Name: Removed from Blinded Dataset
    - 16d4) Maternal Last Name: Removed from Blinded Dataset

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17) (do not ask) Did the participant have a sixth episode? (if 'No', go to 20) .....  **MCF17**

18) For the sixth episode of breathing problems you had since (date):

18a) Did you take additional antibiotics after contacting your healthcare provider by telephone or email? (Y/N) .....  **MCF18a**

18b) Did you take additional oral steroids after contacting your healthcare provider by telephone or email? (Y/N).....  **MCF18b**

18c) Did you take additional antibiotics but without contacting a healthcare provider? (Y/N) .....  **MCF18c**

18d) Did you take additional oral steroids but without contacting a healthcare provider? (Y/N).....  **MCF18d**

18e) Were you evaluated in a physician's office or urgent care? (Y/N).....  **MCF18e**

During that visit were you given (check all that apply):

18e1) An additional antibiotic .....  **MCF18e1**

18e2) Additional steroids .....  **MCF18e2**

18e3) Don't know .....  **MCF18e3**

18e4) Don't remember .....  **MCF18e4**

18f) Were you evaluated in an Emergency Department? .....  **MCF18f**

During that visit were you given (check all that apply):

18f1) An additional antibiotic .....  **MCF18f1**

18f2) Additional steroids .....  **MCF18f2**

18f3) Don't know .....  **MCF18f3**

18f4) Don't remember .....  **MCF18f4**

18g) What was the date of this event? .....   /   /      **MCF18g**

18h) What is the name of the medical facility? **Removed from Blinded Dataset**

18i) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

18j) For clarification of our records, under what name is this record?

18j1) First Name: **Removed from Blinded Dataset**

18j2) Second Name: **Removed from Blinded Dataset**

18j3) Last Name: **Removed from Blinded Dataset**

18j4) Maternal Last Name: **Removed from Blinded Dataset**

18k) Were you admitted to the hospital? .....  **MCF18k**

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If participant was admitted to hospital:

19a) What was the date of this event?.....   /   /         **MCF19a**

19b) What is the name of the medical facility? **Removed from Blinded Dataset**

19c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

19d) For clarification of our records, under what name is this record?

19d1) First Name: **Removed from Blinded Dataset**

19d2) Second Name: **Removed from Blinded Dataset**

19d3) Last Name: **Removed from Blinded Dataset**

19d4) Maternal Last Name: **Removed from Blinded Dataset**

20) Since your last (*center visit or telephone contact*) on (*date*), have you at any time been admitted to a hospital for any reason other than a chest flare up? **MCF20**

No 0  → **Go to Item 27**

Yes 1

Unsure 9  → **Go to Item 27**

20a) How many hospitalizations have you had since (*date*)?.....  **MCF20a**

**INTERVIEWER:** The next few questions are about one event. If there were more than one we would like to talk about each one separately. Let's start with the first event after your (*visit or teleconference*) on (*date*)."

21a) What was the date of this event? .....   /   /         **MCF21a**

21b) What is the name of the medical facility? **Removed from Blinded Dataset**

21c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

21d) For clarification of our records, under what name is this record?

21d1) First Name: **Removed from Blinded Dataset**

21d2) Second Name: **Removed from Blinded Dataset**

21d3) Last Name: **Removed from Blinded Dataset**

21d4) Maternal Last Name: **Removed from Blinded Dataset**

21e) Were you admitted to a hospital at any other time since your last (*center visit or telephone contact*)?

No 0  → **Go to Item 27** **MCF21e**

Yes 1



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22a) What was the date of this event? ..... / **MCF22a**

22b) What is the name of the medical facility? **Removed from Blinded Dataset**

22c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

22d) For clarification of our records, under what name is this record?

22d1) First Name: **Removed from Blinded Dataset**

22d2) Second Name: **Removed from Blinded Dataset**

22d3) Last Name: **Removed from Blinded Dataset**

22d4) Maternal Last Name: **Removed from Blinded Dataset**

22e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **MCF22e**  
Yes 1

23a) What was the date of this event? ..... / **MCF23a**

23b) What is the name of the medical facility? **Removed from Blinded Dataset**

23c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

23d) For clarification of our records, under what name is this record?

23d1) First Name: **Removed from Blinded Dataset**

23d2) Second Name: **Removed from Blinded Dataset**

23d3) Last Name: **Removed from Blinded Dataset**

23d4) Maternal Last Name: **Removed from Blinded Dataset**

23e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?  
No 0  → **Go to Item 27** **MCF23e**  
Yes 1

24a) What was the date of this event? ..... / **MCF24a**

24b) What is the name of the medical facility? **Removed from Blinded Dataset**

24c) What is the address of this medical facility? **Removed from Blinded Dataset**  
(Leave blank if unknown)

24d) For clarification of our records, under what name is this record?

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24d1) First Name: Removed from Blinded Dataset

24d2) Second Name: Removed from Blinded Dataset

24d3) Last Name: Removed from Blinded Dataset

24d4) Maternal Last Name: Removed from Blinded Dataset

24e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **MCF24e**  
Yes 1

25a) What was the date of this event? .....   /   /     **MCF25a**

25b) What is the name of the medical facility? Removed from Blinded Dataset

25c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

25d) For clarification of our records, under what name is this record?

25d1) First Name: Removed from Blinded Dataset

25d2) Second Name: Removed from Blinded Dataset

25d3) Last Name: Removed from Blinded Dataset

25d4) Maternal Last Name: Removed from Blinded Dataset

25e) Were you admitted to a hospital at any other time since your last (*center visit* or *telephone contact*)?

No 0  → **Go to Item 27** **MCF25e**  
Yes 1

26a) What was the date of this event? .....   /   /     **MCF26a**

26b) What is the name of the medical facility? Removed from Blinded Dataset

26c) What is the address of this medical facility? Removed from Blinded Dataset  
(Leave blank if unknown)

26d) For clarification of our records, under what name is this record?

26d1) First Name: Removed from Blinded Dataset

26d2) Second Name: Removed from Blinded Dataset

26d3) Last Name: Removed from Blinded Dataset

26d4) Maternal Last Name: Removed from Blinded Dataset

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**INTERVIEWER:** I'd now like to ask you some other questions about your health since your last (*clinic visit or telephone contact*) on (*date*).

Since your last (*clinic visit or telephone contact*) on (*date*)

27) Did your doctor put you on oxygen? (Y/N) .....  **MCF27**

28) Have you been listed for or received a lung transplant? (Y/N) .....  **MCF28**

29) Are you currently smoking cigarettes? (Y/N) .....  **MCF29**

30) Since your last (*clinic visit or telephone contact*) on (*date*), have you been diagnosed with other medical problems or been injured? (Y/ N) .....  **MCF30**

If answered 'Yes' to question 30

31) Were you diagnosed with:

31a) Lung cancer (Y/N) .....  **MCF31a**

31b) Other type of cancer (Y/N) .....  **MCF31b**

If so, what type? **MCF31b1** \_\_\_\_\_

31c) Diabetes (Y/N) .....  **MCF31c**

31d) Blood Clots (Y/N) .....  **MCF32**

31e) Osteoporosis (Y/N) .....  **MCF33**

31f) Broken Hip (Y/N) .....  **MCF34**

31g) Heart attack or myocardial infarction (Y/N) .....  **MCF35**

31h) Stroke (Y/N) .....  **MCF36**

31i) Coronary artery disease (atherosclerosis) (Y/N) .....  **MCF37**



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*[Do not read]Cough Episodes: Severity on Arising and Throughout the Day*

3) How severe were your cough episodes on a typical day during the past week?..... **MCQ03**

- None: Unaware of coughing ..... 1
- Mild: Did not interfere with usual morning or daily activity ..... 2
- Moderate: Must stop activity during coughing episode..... 3
- Marked: Must stop activity during and for a brief period after coughing episode..... 4
- Severe: Stops all activity for some time and is exhausting; can be accompanied by dizziness, headache or pain ..... 5

*[Do not read]Ease of Bringing Up Sputum During the Day*

4) How easy is it to cough up sputum when you cough today?..... **MCQ04**

- None: Unaware of coughing at all..... 1
- Easy: Sputum comes up without difficulty after only one or two coughs..... 2
- Somewhat difficult: Most of the sputum comes up but only after several hard coughs ..... 3
- Very difficult: Some sputum comes up after hard coughing but there is the feeling that most is still sticking down there..... 4
- Impossible: There is sputum down there but no matter how hard the coughing nothing comes up..... 5

*[Do not read]Chest Discomfort: Tightness and/or Congestion and Arising and Throughout the Day*

5) How much chest tightness or discomfort do you have today?..... **MCQ05**

- None: Unaware of any discomfort..... 1
- Mild: Noticeable now-and-then but is not bothersome and passes quickly; does not limit activity ..... 2
- Moderate: Noticeable during light activity such as walking one block or up one flight of stairs ..... 3
- Marked: Noticeable while washing or dressing in the morning..... 4
- Severe: Almost constant and limits all activity; present even while resting ..... 5

Rubin BK, Ramirez O, & Ohar JA. Iodinated glycerol has no effect on sputum properties, pulmonary function, or symptom score in patients with stable chronic bronchitis. *Chest* 1996;109:348-352



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| f) Palpitations, irregular heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF5F1</b> |
| g) Valve disease                     | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF5G1</b> |
| h) Congestive heart failure          | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF5H1</b> |
| i) Blood clots                       | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF5I1</b> |
| j) Poor circulation (claudication)   | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF5J1</b> |
| k) Other                             | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF5K1</b> |
- 
- |                                    |                          |                          |                |
|------------------------------------|--------------------------|--------------------------|----------------|
| <b>6) Gastrointestinal</b>         | <u>Yes</u>               | <u>No</u>                | <u>Explain</u> |
| a) Esophageal condition or disease | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6A1</b>  |
| b) Ulcers                          | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6B1</b>  |
| c) Hepatitis or jaundice           | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6C1</b>  |
| d) Crohn's disease or colitis      | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6D1</b>  |
| e) Gallstones                      | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6E1</b>  |
| f) Cirrhosis                       | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6F1</b>  |
| g) GERD (heart burn)               | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6G1</b>  |
| h) Hiatal hernia                   | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6H1</b>  |
| i) Other                           | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF6I1</b>  |
- 
- |                                  |                          |                          |                |
|----------------------------------|--------------------------|--------------------------|----------------|
| <b>7) Pulmonary/vascular</b>     | <u>Yes</u>               | <u>No</u>                | <u>Explain</u> |
| a) Intubation or respirator      | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF7A1</b>  |
| b) Pneumothorax (collapsed lung) | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF7B1</b>  |
| c) Tuberculosis                  | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF7C1</b>  |
| d) Pulmonary fibrosis            | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF7D1</b>  |
| e) Lung nodules                  | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF7E1</b>  |
| f) Pulmonary embolism            | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF7F1</b>  |
| g) Other                         | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF7G1</b>  |
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- |   |                          |                          |                |
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| <b>8) Oncology/hematology</b>             | <u>Yes</u>               | <u>No</u>                | <u>Explain</u> |
| a) Cancer (except basal cell skin cancer) | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF8A1</b>  |
| b) Anemia                                 | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF8B1</b>  |
| c) Other                                  | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF8C1</b>  |
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- |  |                          |                          |                |
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| <b>9) Genitourinary and reproductive</b> | <u>Yes</u>               | <u>No</u>                | <u>Explain</u> |
| a) Menstrual symptoms (women)            | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF9A1</b>  |
| b) Enlarged prostate or BPH (men)        | <input type="checkbox"/> | <input type="checkbox"/> | <b>MHF9B1</b>  |

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- c) Bladder or kidney problems/ kidney stones **MHF9C**   **MHF9C1** \_\_\_\_\_
- d) Other **MHF9D**   **MHF9D1** \_\_\_\_\_

- 10) Endocrine Yes  No  Explain
- a) Diabetes **MHF10A**   **MHF10A1** \_\_\_\_\_
- b) Thyroid **MHF10B**   **MHF10B1** \_\_\_\_\_
- c) Other **MHF10C**   **MHF10C1** \_\_\_\_\_

- 11) Neurology Yes  No  Explain
- a) Stroke **MHF11A**   **MHF11A1** \_\_\_\_\_
- b) Headaches **MHF11B**   **MHF11B1** \_\_\_\_\_
- c) Seizure **MHF11C**   **MHF11C1** \_\_\_\_\_
- d) Other **MHF11D**   **MHF11D1** \_\_\_\_\_

- 12) Muscular/skeletal Yes  No  Explain
- a) Rheumatoid arthritis **MHF12A**   **MHF12A1** \_\_\_\_\_
- b) Gout **MHF12B**   **MHF12B1** \_\_\_\_\_
- c) Osteoporosis **MHF12C**   **MHF12C1** \_\_\_\_\_
- d) Fractures **MHF12D**   **MHF12D1** \_\_\_\_\_
- e) Joint pain **MHF12E**   **MHF12E1** \_\_\_\_\_
- f) Osteoarthritis **MHF12F**   **MHF12F1** \_\_\_\_\_
- g) Other **MHF12G**   **MHF12G1** \_\_\_\_\_

- 13) Dermatology Yes  No  Explain
- a) Rashes/hives/eczema **MHF13A**   **MHF13A1** \_\_\_\_\_
- b) Psoriasis **MHF13B**   **MHF13B1** \_\_\_\_\_
- c) Shingles **MHF13C**   **MHF13C1** \_\_\_\_\_
- d) Other **MHF13D**   **MHF13D1** \_\_\_\_\_

- 14) Infectious disease Yes  No  Explain
- a) Atypical mycobacteria (MAC, MAI) **MHF14A**   **MHF14A1** \_\_\_\_\_
- b) Fungal disease **MHF14B**   **MHF14B1** \_\_\_\_\_
- c) Other **MHF14C**   **MHF14C1** \_\_\_\_\_

- 15) Psychiatric Yes  No  Explain
- a) Anxiety **MHF15A**   **MHF15A1** \_\_\_\_\_
- b) Depression **MHF15B**   **MHF15B1** \_\_\_\_\_
- c) Other **MHF15C**   **MHF15C1** \_\_\_\_\_



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16) Other significant problems Yes No  
 not reported in questions 2-18  **MHF16**

- a) **MHF16A** \_\_\_\_\_
- b) **MHF16B** \_\_\_\_\_
- c) **MHF16C** \_\_\_\_\_
- d) **MHF16D** \_\_\_\_\_
- e) **MHF16E** \_\_\_\_\_

**These next questions refer to recent illnesses or problems you may have had.**

In the last two weeks have you had any of the following:

- 17) A fever, cold, flu, or sore throat? (Y/N) .....  **MHF17**
- 18) A urinary tract infection? (Y/N) .....  **MHF18**
- 19) Seasonal allergies? (Y/N).....  **MHF19**
- 20) A sinus infection or sinusitis? (Y/N) .....  **MHF20**
- 21) A tooth infection? (Y/N) .....  **MHF21**
- 22) A flare up of gout? (Y/N).....  **MHF22**
- 23) A flare up of arthritis? (Y/N) .....  **MHF23**
- 24) Other? (Y/N).....  **MHF24**
- 25) Please explain: **MHF25** \_\_\_\_\_

26) Are you allergic to any medications, latex, food, or substances? (Y/N) .....  **MHF26**

If **YES**:

List substance:	Reaction
a) <b>MHF26A</b>	<b>MHF26A1</b>
b) <b>MHF26B</b>	<b>MHF26B1</b>
c) <b>MHF26C</b>	<b>MHF26C1</b>
d) <b>MHF26D</b>	<b>MHF26D1</b>
e) <b>MHF26E</b>	<b>MHF26E1</b>

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27) In the past 12 months, how often have you consumed any alcohol containing beverage (beer, wine, wine coolers, liquor, or mixed drinks such as margaritas, martinis, or daiquiris)? (check only one) **MHF27**

- Every Day .....
- 4 to 6 days per week .....
- 2 to 3 days per week .....
- Once per week .....
- 1 to 3 times per month .....
- Less than once per month .....
- No alcohol in the past 12 months .....  → **Go to 34**

28) When you drink alcohol containing beverages, how many do you usually drink at one sitting? (check only one) **MHF28**

- 1 or 2 .....
- 3 or 4 .....
- 5 or 6 .....
- More than 6 .....

29) What kind of alcoholic beverages do you usually drink? (check all that apply)

- Beer .....  **MHF29A**
- Wine .....  **MHF29B**
- Drinks containing liquor .....  **MHF29C**

30) How often do you have eight or more drinks on one occasion? **MHF30**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....

31) How often during the last year have you been unable to remember what happened the night before because you had been drinking? **MHF31**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....

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32) How often during the last year have you failed to do what was normally expected of you because of your drinking? **MHF32**

- Never .....
- Less than monthly .....
- Monthly .....
- Weekly .....
- Daily or almost daily .....

33) Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down? **MHF33**

- No .....
- Yes, but not in the last year .....
- Yes in the last year .....

If participant is MALE, skip to 46  
If participant is FEMALE, continue

34) Have you reached menopause? .....  **MHF34**

- Yes ..... Y
- No ..... N → **Go to 36**
- I don't know ..... U → **Go to 36**

35) If you have reached menopause, at what age did that occur? .....   yrs old **MHF35**

36) Did you ever use oral contraceptive medications? .....  **MHF36**

- Yes ..... Y
- No ..... N → **Go to 38**

37) If you did use oral contraceptives, for how many years? .....   years **MHF37**

38) Did you ever use hormone replacement therapy? .....  **MHF38**

- Yes ..... Y
- No ..... N → **Go to 40**

39) If you did use hormone replacement therapy, for how many years? .....   years **MHF39**

40) In the last 12-months have you been pregnant? .....   **MHF40**

41) In the last 12-months did you ever breastfeed? .....  **MHF41**

- Yes ..... Y
- No ..... N → **Go to 43**

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42) If you did breastfeed, for approximately how many total months did you breastfeed  
(total for all pregnancies)? ..... 

--	--

 months **MHF42**

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

--

**MHF43**  
Yes ..... Y  
No ..... N → **Go to 46**

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

--

**MHF44**  
One ..... O  
Both ..... B

45) At what age was your ovary or ovaries removed? ..... 

--	--

 yrs old **MHF45**

46) Were you born premature? ..... 

--

**MHF46**  
Yes ..... Y  
No ..... N → **Go to 47**  
Don't Know ..... D → **Go to 47**

46a) If yes, how many weeks were you premature? ..... 

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 weeks **MHF46A**

47) What was your birth weight? ..... 

--	--

 pounds 

--	--

 ounces **MHF47A** **MHF47B**

48) Did you ever have breathing problems during the first two years of life? ..... 

--

**MHF48**  
Yes ..... Y  
No ..... N → **Go to 49**  
Don't Know ..... D → **Go to 49**

48a) If yes, were you ever hospitalized for these problems? ..... 

--

**MHF48A**  
Yes ..... Y  
No ..... N  
Don't Know ..... D

49) Were you ever hospitalized for pneumonia before 18 years of age? ..... 

--

**MHF49**  
Yes ..... Y  
No ..... N  
Don't Know ..... D



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## B. PRESENTING SIGNS AND SYMPTOMS

	<u>Yes</u>	<u>No</u>	<u>NR</u> Not recorded
10. Did the onset of the acute episode occur prior to admission? <span style="float: right;"><b>MIF10</b></span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. If Yes, estimate the time from onset of symptoms of acute condition to arrival at the hospital: <span style="float: right;"><b>MIF10A</b></span>			
< 1hr <input type="checkbox"/>	≥ 1- < 3 hrs <input type="checkbox"/>	≥ 3 - < 6 hrs <input type="checkbox"/>	Unsure <input type="checkbox"/>
≥ 6 - < 12 hrs <input type="checkbox"/>	≥ 12 - < 24 hrs <input type="checkbox"/>	≥ 24 hrs <input type="checkbox"/>	
	<u>Yes</u>	<u>No</u>	<u>NR</u>
11. Was there mention of an acute CHD event with onset <u>after</u> arrival at the hospital? <span style="float: right;"><b>MIF11</b></span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Was there an acute episode(s) of pain or discomfort (eg: tightness) anywhere in the chest, arm, shoulder throat or jaw, either within 72 hours prior to arrival to the hospital, or in conjunction with the in-hospital CHD event? <i>(If No or NR, skip to 13)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>MIF12</b>
a. Did this pain or discomfort specifically involve the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>MIF12A</b>
b. Did the pain get worse (crescendo) over time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>MIF12B</b>
c. Was the pain or discomfort diagnosed as having a non-cardiac origin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>MIF12C</b>
13. Was there nausea or vomiting associated with this event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>MIF13</b>
14. Was there diaphoresis associated with this event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>MIF14</b>
15. Was there fatigue or malaise associated with this event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Vital Signs at arrival (or event onset) and not during CPR			
a. Blood pressure <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> mmHg <span style="float: right;"><b>MIF16A</b></span>			
b. Heart rate <input type="text"/> <input type="text"/> <input type="text"/> bpm <span style="float: right;"><b>MIF16B</b></span>			

## C. MEDICAL HISTORY

	<u>Yes</u>	<u>No/NR</u>
17. Prior to this event was there history of any of the following:		
a. Myocardial infarction <i>(If No or NR, skip to 17b)</i> <span style="float: right;"><b>MIF17A</b></span>	<input type="checkbox"/>	<input type="checkbox"/>
a1. If history of MI, then MI within 4 weeks of this event?	<input type="checkbox"/> <b>MIF17A1</b>	<input type="checkbox"/>
b. Angina <span style="float: right;"><b>MIF17B</b></span>	<input type="checkbox"/>	<input type="checkbox"/>
c. Percutaneous coronary intervention (PCI) <span style="float: right;"><b>MIF17C</b></span>	<input type="checkbox"/>	<input type="checkbox"/>
d. CABG <span style="float: right;"><b>MIF17D</b></span>	<input type="checkbox"/>	<input type="checkbox"/>
e. Coronary artery disease (CAD) <span style="float: right;"><b>MIF17E</b></span>	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart failure <span style="float: right;"><b>MIF17F</b></span>	<input type="checkbox"/>	<input type="checkbox"/>
g. Arrhythmia <span style="float: right;"><b>MIF17G</b></span>	<input type="checkbox"/>	<input type="checkbox"/>

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If Yes, specify type of arrhythmia

- |   |                          |                          |         |
|---|--------------------------|--------------------------|---------|
| g1 Atrial Fibrillation/Flutter          | <input type="checkbox"/> | <input type="checkbox"/> | MIF17G1 |
| g2 Ventricular Fibrillation/Tachycardia | <input type="checkbox"/> | <input type="checkbox"/> | MIF17G2 |
| g3 Other arrhythmia                     | <input type="checkbox"/> | <input type="checkbox"/> | MIF17G3 |

**D. ACTIVE OR CURRENT MEDICAL PROBLEMS (DURING THIS HOSPITALIZATION)**

18. Did a physician indicate any of these as being present during the hospitalization? Yes  No
- |   |                          |                          |        |
|---|--------------------------|--------------------------|--------|
| a. Angina   | <input type="checkbox"/> | <input type="checkbox"/> | MIF18A |
| b. Acute myocardial Infarction  | <input type="checkbox"/> | <input type="checkbox"/> | MIF18B |
| c. ST elevation > 1mm with pain that is not present on ECG without pain | <input type="checkbox"/> | <input type="checkbox"/> | MIF18C |
| d. Congestive heart failure exacerbation or pulmonary edema             | <input type="checkbox"/> | <input type="checkbox"/> | MIF18D |
| e. Shock or cardiogenic shock   | <input type="checkbox"/> | <input type="checkbox"/> | MIF18E |
| f. Ventricular fibrillation, cardiac arrest or asystole                 | <input type="checkbox"/> | <input type="checkbox"/> | MIF18F |
| g. Ventricular Tachycardia  | <input type="checkbox"/> | <input type="checkbox"/> | MIF18G |
| h. Atrial fibrillation or atrial flutter                                | <input type="checkbox"/> | <input type="checkbox"/> | MIF18H |

**E. BIOMARKERS**

19. Were cardiac enzymes reported within days 1-4 after arrival at the hospital or after the in-hospital CHD event? *(If No/NR skip to 32)* Yes  No/NR  MIF19

**Biomarker Laboratory Standards:**

\*Units: 1= ng/mL 2 = Units/L 3 = µg/L

20. Normal Lab Value Ranges *(this facility)*

- |                                     | Upper limit of normal  | Units*                               |
|-------------------------------------|--|--------------------------------------|
| a. Total CK (CPK)                   | a1. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MIF20A1 | a2. <input type="checkbox"/> MIF20A2 |
| b. CK-MB                            | b1. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MIF20B1 | b2. <input type="checkbox"/> MIF20B2 |
| c. Troponin                         | c1. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MIF20C1 | c2. <input type="checkbox"/> MIF20C2 |
| c3. What type of Troponin was this? | <input type="checkbox"/> MIF20C3   |                                      |
| 1= Troponin, type not specified     | 4= High Sensitivity Troponin (HS)  |                                      |
| 2= Troponin I                       | 5= Unsure  |                                      |
| 3= Troponin T                       |  |                                      |







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32. Was any stress test (treadmill, pharmacologic, or nuclear medicine) performed during this admission: (If No/NR, skip to 33)   **MIF32**

a. Ejection fraction: LV: % **MIF32A**

b. Stress test positive for ischemia   **MIF32B**

c. Greater than or equal to 1mm ST depression or elevation   **MIF32C**

d. Ischemic pain or equivalent occurred   **MIF32D**

33. Was a coronary angiography performed? (If No/NR, skip to 34)   **MIF33**

a. Date: (mm/dd/yyyy) // **MIF33A**

b. Ejection fraction: LV: % **MIF33B** Yes No NR

c. 70% or greater obstruction of any coronary artery    **MIF33C**

d. Were coronary bypass grafts present?    **MIF33D**

d1. If yes, number of occluded grafts:  **MIF33D1**

**G. Treatment** Yes No/NR

34. Was coronary reperfusion (CABG, PCI, thrombolysis) attempted? (If No/NR, skip to 40)   **MIF34**

a. If yes, what was the approximate time from event onset to reperfusion? **MIF34A**

< 2 hours  2 - <4 hours  4 - <6 hours  6 - <12 hours

12 - <24 hours  24+ hours  not sure

35. Where any of the following treatments given during this hospitalization? Yes No

a. Coronary artery bypass graft surgery (CABG)   **MIF35A**

a1. If yes, Date: /  **MIF35A1**

b. Coronary atherectomy   **MIF35B**

b1. If yes, Date: /  **MIF35B1**

c. Intra-arterial or intravenous thrombolytic   **MIF35C**

c1. If yes, Date: /  **MIF35C1**

d. Coronary angioplasty without stent   **MIF35D**

d1. If yes, Date: /  **MIF35D1**

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e. Coronary angioplasty with stent placement   MIF35E

e1. If yes, Date: /   MIF35E1

f. Valve surgery   MIF35F

g. Non-cardiac surgery   MIF35G

h. Aortic balloon pump   MIF35H

i. Pacemaker placement (temporary or permanent)   MIF35I

j. Cardioversion or defibrillation   MIF35J

j1. If yes, Date: /   MIF35J1

j2. If cardioversion took place after arrival at the hospital, what rhythm(s) were present prior to cardioversion?

- |  |          | Yes                      | No                                |
|--|----------|--------------------------|-----------------------------------|
| a. Ventricular Fibrillation/Flutter (Yes/no) | MIF35J2A | <input type="checkbox"/> | <input type="checkbox"/> MIF35J2B |
| b. Ventricular Tachycardia (VT)              |          | <input type="checkbox"/> | <input type="checkbox"/> MIF35J2C |
| c. Asystole                                  |          | <input type="checkbox"/> | <input type="checkbox"/> MIF35J2D |
| d. Complete AV Block (3 HB)                  |          | <input type="checkbox"/> | <input type="checkbox"/> MIF35J2E |
| e. Atrial Fibrillation/Flutter               |          | <input type="checkbox"/> | <input type="checkbox"/> MIF35J2F |
| f. Pulseless Electrical Activity (PEA)       |          | <input type="checkbox"/> | <input type="checkbox"/> MIF35J2G |

36. During the hospitalization or at discharge, did the participant receive any of the following medications?

	Admission Yes	Meds No/NR	Discharge Yes	Meds No/NR
a. Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/> MIF36A	<input type="checkbox"/>	<input type="checkbox"/> MIF36A1
b. Beta Blockers	<input type="checkbox"/>	<input type="checkbox"/> MIF36B	<input type="checkbox"/>	<input type="checkbox"/> MIF36B1
c. Calcium Channel Blockers	<input type="checkbox"/>	<input type="checkbox"/> MIF36C	<input type="checkbox"/>	<input type="checkbox"/> MIF36C1
d. ACE Inhibitor or ARB	<input type="checkbox"/>	<input type="checkbox"/> MIF36D	<input type="checkbox"/>	<input type="checkbox"/> MIF36D1
e. Scheduled aspirin (not PRN)	<input type="checkbox"/>	<input type="checkbox"/> MIF36E	<input type="checkbox"/>	<input type="checkbox"/> MIF36E1
f. Heparin or Enoxaparin	<input type="checkbox"/>	<input type="checkbox"/> MIF36F	<input type="checkbox"/>	<input type="checkbox"/> MIF36F1
g. Coumadin, warafin, dicumarol	<input type="checkbox"/>	<input type="checkbox"/> MIF36G	<input type="checkbox"/>	<input type="checkbox"/> MIF36G1
h. Anti-platelet agents (non-aspirin)	<input type="checkbox"/>	<input type="checkbox"/> MIF36H	<input type="checkbox"/>	<input type="checkbox"/> MIF36H1
i. Statin	<input type="checkbox"/>	<input type="checkbox"/> MIF36I	<input type="checkbox"/>	<input type="checkbox"/> MIF36I1

37. During this hospitalization was this patient treated with:

	Yes	No/NR
a. IV pressors	<input type="checkbox"/>	<input type="checkbox"/> MIF37A
b. IV nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/> MIF37B
c. Iib / IIIa inhibitors or thrombin inhibitors	<input type="checkbox"/>	<input type="checkbox"/> MIF37C





# PULMONARY FUNCTION ELIGIBILITY FORM

ID NUMBER:	<input type="text" value="BLINDID"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: PFT  
VERSION: 1.0 10/26/10

Visit Number	<input type="text" value="VISIT"/>	SEQ #	<input type="text"/>	<input type="text"/>	<input type="text"/>
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0a) Form Date.....  0b) Initials .....

**Instructions:** This form should be completed prior to conducting pulmonary function testing. 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.

1) Have you eaten a large meal with the last 2 hours? .....    
 Yes ..... Y → **if yes, wait a minimum of 15 minutes prior to PFTs**  
 No ..... N

2) Have you smoked within the last hour? .....    
 Yes ..... Y → **if yes, wait a minimum of 15 minutes prior to PFTs**  
 No ..... N

3) Have you participated in any vigorous exercise in the past 30 minutes? .....    
 Yes ..... Y → **if yes, wait a minimum of 15 minutes prior to PFTs**  
 No ..... N

4) Have you consumed any alcoholic beverages within the past 4 hours? .....    
 Yes ..... Y → **if yes, wait to perform eCO but must be before DLCO (if performed)**  
 No ..... N

5) Have you taken any inhaled or oral medication for your lungs in the past 48 hours? .....    
 Yes ..... Y  
 No ..... N → **Go to item 12**

6) Have you used tiotropium (Spiriva) within in the past 48 hours? .....    
 Yes ..... Y  
 No ..... N → **Go to item 7**

6a) Date  time  AM/PM (circle one)

7) Have you used theophylline (Theo 24, Uniphyll, Theochron) within past 48 hrs? .....    
 Yes ..... Y  
 No ..... N → **Go to item 8**

7a) What is the most recent type of theophylline you have used?:.....    
 1) a once-a-day preparation (Theo 24, Uniphyll)

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- 2) an extended release preparation (Theochron, generic SR)
- 3) an immediate release preparation (Elixophyllin, Theolair)

7b) Date / /  time  AM/PM (circle one)

8) Have you used another once-a-day bronchodilator within in the past 48 hours? .....

Yes ..... Y

No..... N → **Go to item 9**

8a) Date / /  time  AM/PM (circle one)

8b) Name:

9) Have you used any long-acting (12-hour) beta agonist within in the past 24 hours? .....

Yes ..... Y

No..... N → **Go to item 10**

9a) What is the most recent long acting beta agonist you have used?:.....

- 1) Albuterol sustained release tab. (VoSpire ER):
- 2) Arformoterol (Brovana):
- 3) Formoterol (Dulera, Foradil, Perforomist, Symbicort):
- 4) Salmeterol (Advair Diskus, Advair HFA, Serevent Diskus)
- 5) Other 12 hour beta agonist: Name:

9b) Time  AM/PM (circle one)

10) Have you used ipratropium within the past 8 hours? .....

Yes ..... Y

No..... N → **Go to item 11**

10a) What is the most recent ipratropium or ipratropium/albuterol combination have you used?

- 1) Ipratropium (Atrovent, generic ipratropium nebulizer solution)
- 2) Ipratropium/albuterol combination (Combivent, Duoneb, generic nebulizer solution)

10b) Time  AM/PM (circle one)

**If <300 minutes since last ipratropium dose, see partial dosing instruction in the PFT MOP.**

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11) Have you used any short-acting beta agonist within in the past 6 hours? .....  **PFT11**  
Yes ..... Y  
No..... N → **Go to item 12**

11a) What is the most recent short-acting beta agonist have you used?.....  **PFT11A**  
1) Albuterol (ProAir HFA, Proventil HFA, Ventolin HFA, Acuneb, generic solution, non-sustained release oral tablets)  
2) Epinephrine (Epipen, Twinject, S2, generic)  
3) Levalbuterol (Xopenex HFA, Xopenex solution, generic solution)  
4) Metaproterenol (generic solution, syrup, non-sustained release tablets)  
5) Pirbuterol (Maxair)  
6) Terbutaline (generic tablets)  
7) Other short-acting beta agonist: Name **PFT11A7A**

11b) Time **PFT11B**  AM/PM (*circle one*) **PFT11B\_AMPM**

**If <165 minutes since last short-acting beta agonist dose, see partial dosing instructions in PFT MOP.**

12) Have you had more then 18 oz. of coffee (or equivalent caffeine, 200 mg), in the past 6 hours?  **PFT12**  
Yes ..... Y  
No..... N

200 mg= (roughly): 18 oz of coffee, 4 shots of espresso, 40 oz of tea, 60 oz of a cola soft drink, 16 oz of energy drink





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**CIRCUMSTANCES SURROUNDING DEATH**

4. What do you believe to be the underlying cause of death?  
Please select one of the following categories: Respiratory,  
Cardiovascular, Cancer, Other Known, or Unknown.

(Select only one) .....  **PQE4**

- Respiratory ..... 1 → Go to 4a
- Cardiovascular ..... 2 → Go to 4b
- Cancer ..... 3 → Go to 4c
- Other, Known ..... 4 → Go to 4d
- Unknown ..... 5 → Go to 4e

4a. Respiratory (select only one)? .....  **PQE4A**

- COPD Exacerbation with pneumonia ..... 1
- COPD Exacerbation without pneumonia ..... 2
- COPD without exacerbation ..... 3
- Other respiratory ..... 4

Specify: \_\_\_\_\_ **PQE4A1**

4b. Cardiovascular (select only one)? .....  **PQE4B**

- Myocardial infarction ..... 1
- Heart failure ..... 2
- Stroke/aneurysm ..... 3
- DVT/PE ..... 4
- Other heart problem ..... 5

Specify: \_\_\_\_\_ **PQE4B1**

4b1. Type of Cardiovascular death (select only one)? .....  **PQE4B2**

- a. "Sudden Death," defined as death that occurs within 24 hours of being observed alive and without evidence of a deteriorating medical condition) ..... 1
- b. "Sudden Cardiac Death," defined as death that occurs within 1 hour of being observed alive and without evidence of a deteriorating medical condition ..... 2
- c. Neither of the above ..... 3

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4c. Cancer (select only one)? .....  **PQE4C**

Lung ..... 1

Other cancer ..... 2

Specify: \_\_\_\_\_ **PQE4C1**

4d. Other, Known

Specify: \_\_\_\_\_ **PQE4D**

4e. Reason for Unknown cause of death (select only one)?.....  **PQE4E**

Information is inadequate.....1

Indeterminate (information available but cause unclear).....2

5. Do you believe that a diagnosis of COPD contributed to the death of this individual?.....  **PQE5**

Yes .....1

No .....2

Comments:

**Removed from Blinded Dataset**

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6. Did you see the participant within one month of death? .....  **PQE6**

No.....N Please skip to Question 8

Yes.....Y

7. If yes, please fill out the following for the most recent visit:

7a. Date of visit:   /   /     **PQE7A**  
Month day year

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7b. Chief Complaint: \_\_\_\_\_ PQE7B

7c. Primary Diagnosis: \_\_\_\_\_ PQE7C

7d. Changes in Medical Management: \_\_\_\_\_ PQE7D

8. Is there any other pertinent information that you think would help us determine the circumstances and underlying conditions that may have contributed to this individual's death in addition to determining the ultimate cause of death?

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Form completed by: Removed from Blinded Dataset

Date: PQE10



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- b) Wake up in the middle of the night or early morning .....  **PSQ05B**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- c) Have to get up to use the bathroom .....  **PSQ05C**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- d) Cannot breathe comfortably .....  **PSQ05D**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- e) Cough or snore loudly .....  **PSQ05E**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- f) Feel too cold .....  **PSQ05F**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- g) Feel too hot .....  **PSQ05G**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- h) Had bad dreams .....  **PSQ05H**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D

Buysse, D.J., Reynolds, C.F., Monk, T.H., Berman, S.R., & Kupfer, D.J. (1989). The Pittsburgh Sleep Quality Index (PSQI): A new instrument for psychiatric research and practice. *Psychiatry Research*, 28(2), 193-213.

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- i) Had pain .....  **PSQ05I**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week .....C
  - Three or more times a week .....D

j) Other reason(s), please describe **PSQ05J1** \_\_\_\_\_

- How often during the past month have you had trouble sleeping because of this?.....  **PSQ05J**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week .....C
  - Three or more times a week .....D

- 6) During the past month, how would you rate your sleep quality overall? .....  **PSQ06**
- Very good.....A
  - Fairly good .....B
  - Fairly bad .....C
  - Very bad .....D

- 7) During the past month, how often have you take medicine (prescribed or over-the-counter) to help you sleep? .....  **PSAQ7**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week .....C
  - Three or more times a week .....D

- 8) During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity? .....  **PSAQ8**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week .....C
  - Three or more times a week .....D

Buysse,D.J., Reynolds,C.F., Monk,T.H., Berman,S.R., & Kupfer,D.J. (1989). The Pittsburgh Sleep Quality Index (PSQI): A new instrument for psychiatric research and practice. Psychiatry Research, 28(2), 193-213.

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9) During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done? .....  **PSAQ9**  
No problem at all ..... A  
Only a very slight problem..... B  
Somewhat of a problem ..... C  
A very big problem ..... D

10) Do you have a bed partner or roommate? .....  **PSQ10**  
No bed partner or roommate ..... A → **End**  
Partner/roommate in other room ..... B  
Partner in same room, but not same bed..... C  
Partner in same bed ..... D

**If you have a roommate or bed partner, ask him/her how often in the past month you have had:**

a) Loud Snoring .....  **PSQ10A**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

b) Long pauses between breaths while asleep.....  **PSQ10B**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

c) Legs twitching or jerking while you sleep .....  **PSQ10C**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

d) Episodes of disorientation or confusion during sleep.....  **PSQ10D**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

Buysse,D.J., Reynolds,C.F., Monk,T.H., Berman,S.R., & Kupfer,D.J. (1989). The Pittsburgh Sleep Quality Index (PSQI): A new instrument for psychiatric research and practice. *Psychiatry Research*, 28(2), 193-213.

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e) Other restlessness while you sleep; please describe: **PSQ10E1** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ ..... 

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**PSQ10E**

- Not during the past month ..... A
- Less than once a week ..... B
- Once or twice a week ..... C
- Three or more times a week ..... D





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- b) Wake up in the middle of the night or early morning .....  **PSQ05B**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- c) Have to get up to use the bathroom .....  **PSQ05C**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- d) Cannot breathe comfortably .....  **PSQ05D**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- e) Cough or snore loudly .....  **PSQ05E**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- f) Feel too cold .....  **PSQ05F**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- g) Feel too hot .....  **PSQ05G**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D
- h) Had bad dreams .....  **PSQ05H**  
    Not during the past month ..... A  
    Less than once a week ..... B  
    Once or twice a week ..... C  
    Three or more times a week ..... D

Buysse, D.J., Reynolds, C.F., Monk, T.H., Berman, S.R., & Kupfer, D.J. (1989). The Pittsburgh Sleep Quality Index (PSQI): A new instrument for psychiatric research and practice. *Psychiatry Research*, 28(2), 193-213.

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- i) Had pain .....  **PSQ05I**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week.....C
  - Three or more times a week.....D

j) Other reason(s), please describe **PSQ05J1** \_\_\_\_\_

- How often during the past month have you had trouble sleeping because of this?.....  **PSQ05J**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week.....C
  - Three or more times a week.....D

- 6) During the past month, how would you rate your sleep quality overall? .....  **PSQ06**
- Very good.....A
  - Fairly good .....B
  - Fairly bad .....C
  - Very bad .....D

- 7) During the past month, how often have you take medicine (prescribed or over-the-counter) to help you sleep? .....  **PSAQ7**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week.....C
  - Three or more times a week.....D

- 8) During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity? .....  **PSAQ8**
- Not during the past month .....A
  - Less than once a week .....B
  - Once or twice a week.....C
  - Three or more times a week.....D

Buysse,D.J., Reynolds,C.F., Monk,T.H., Berman,S.R., & Kupfer,D.J. (1989). The Pittsburgh Sleep Quality Index (PSQI): A new instrument for psychiatric research and practice. Psychiatry Research, 28(2), 193-213.

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9) During the past month, how much of a problem has it been for you to keep up  
enough enthusiasm to get things done? .....  **PSAQ9**  
No problem at all ..... A  
Only a very slight problem..... B  
Somewhat of a problem ..... C  
A very big problem ..... D

10) Do you have a bed partner or roommate? .....  **PSQ10**  
No bed partner or roommate ..... A → **End**  
Partner/roommate in other room ..... B  
Partner in same room, but not same bed..... C  
Partner in same bed ..... D

**If you have a roommate or bed partner, as him/her how often in the past month  
you have had:**

a) Loud Snoring .....  **PSQ10A**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

b) Long pauses between breaths while asleep.....  **PSQ10B**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

c) Legs twitching or jerking while you sleep .....  **PSQ10C**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

d) Episodes of disorientation or confusion during sleep.....  **PSQ10D**  
Not during the past month ..... A  
Less than once a week ..... B  
Once or twice a week ..... C  
Three or more times a week..... D

Buysse, D.J., Reynolds, C.F., Monk, T.H., Berman, S.R., & Kupfer, D.J. (1989). The Pittsburgh Sleep Quality Index (PSQI): A new instrument for psychiatric research and practice. *Psychiatry Research*, 28(2), 193-213.

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e) Other restlessness while you sleep; please describe: PSQ10E1 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_..... 

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PSQ10E

- Not during the past month .....A
- Less than once a week .....B
- Once or twice a week .....C
- Three or more times a week.....D



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- 7) In the past 12 months, have you had periods or episodes of cough with phlegm that lasted 1 week or more? (If you usually have cough and phlegm, please count only periods or episodes of increased cough and phlegm). (Y/N) .....  **RDF7**
- 7a) If **yes (Y)**, about how many such episodes have you had in the past 12 months? .....   **RDF7A**
- 7b) If **yes (Y)**, for how many years have you had at least one such episode per year? .....   **RDF7B**
- 8) Have you ever had wheezing or whistling in your chest? (Y/N) (If **NO**, go to 11) .....  **RDF8**
- 8a) If **yes (Y)**, about how old were you when you first had wheezing or whistling in your chest? .....   **RDF8A**
- 9) Have you ever had an attack of wheezing or whistling in your chest that made you feel short of breath? (Y/N).....  **RDF9**
- 9a) If **yes (Y)**, about how old were you when you had your first such attack? .....   **RDF9A**
- 9b) Have you ever had 2 or more such attacks? (Y/N) .....  **RDF9B**
- 9c) Have you ever required medicine or treatment for such attacks? (Y/N) .....  **RDF9C**
- 10) In the last 12 months, have you had wheezing or whistling in your chest at any time? (Y/N) .....  **RDF10**
- 10a) If **yes (Y)**, in the last 12 months, does your chest ever sound wheezy or whistling...
- |                                |                              |                             |                |
|--------------------------------|------------------------------|-----------------------------|----------------|
| When you have a cold?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>RDF10A1</b> |
| Occasionally apart from colds? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>RDF10A2</b> |
| More than once a week?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>RDF10A3</b> |
| Most days or nights?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>RDF10A4</b> |
- 11) In the last 12 months, have you been awakened from sleep by coughing, apart from a cough associated with a cold or chest infection? (Y/N) .....  **RDF11**
- 12) In the last 12 months, have you been awakened from sleep by shortness of breath or a feeling of tightness in your chest? (Y/N).....  **RDF12**

Questions 13-14 are about symptoms that occur when you do not have a cold or the flu.

- 13) In the past 12 months, have you had wheezing or whistling in your chest at any time? (Y/N).....  **RDF13**
- 14) In the past 12 months, have you been bothered by watery, itchy, or burning eye when you did not have a cold or the flu? (Y/N) .....  **RDF14**
- 15) Are you unable to walk due to a condition other than shortness of breath? (Y/N) .....  **RDF15**
- Nature of condition: **RDF15A** \_\_\_\_\_

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**These next questions relate to respiratory conditions**

16) In the past 12 months, have you been newly diagnosed by a doctor or other health professional with asthma?.....  **RDF16**

- Yes ..... Y
- No ..... N → **Go to Item 17**
- Don't know ..... U → **Go to Item 17**

16a) In the past 12 months, have you received medical treatment, taken medications, or used an inhaler for asthma? (Y/N) .....  **RDF16A**

17) In the past 12 months, have you had any hay fever (allergy involving the nose and/or eyes)? .....  **RDF17**

- Yes ..... Y
- No ..... N → **Go to Item 18**
- Don't know ..... U → **Go to Item 18**

17a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDF17A**

17b) In the past 12 months, have you received medical treatment, taken medications, or used a nasal spray for hay fever? (Y/N) .....  **RDF17B**

18) In the past 12 months, have you had an attack of bronchitis? .....  **RDF18**

- Yes ..... Y
- No ..... N → **Go to Item 19**
- Don't know ..... U → **Go to Item 19**

18a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDF18A**

18b) How many times have you had bronchitis in the past 12 months? .....   **RDF18B**

19) In the past 12 months, have you had pneumonia or bronchopneumonia?.....  **RDF19**

- Yes ..... Y
- No ..... N → **Go to Item 20**
- Don't know ..... U → **Go to Item 20**

19a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDF19A**

19b) How many times have you had pneumonia or bronchopneumonia in the past 12 months? .....   **RDF19B**

20) In the past 12 months, were you newly diagnosed by a doctor or other health professional with chronic bronchitis?.....  **RDF20**

- Yes ..... Y
- No ..... N → **Go to Item 21**
- Don't know ..... U → **Go to Item 21**

20a) In the past 12 months, have you received medical treatment, taken medications or used an inhaler for chronic bronchitis? (Y/N) .....  **RDF20A**



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21) In the past 12 months, have you been newly diagnosed by a doctor or other health professional with emphysema?.....  **RDF21**

- Yes ..... Y
- No ..... N → **Go to Item 22**
- Don't know ..... U → **Go to Item 22**

21a) In the past 12 months, have you received medical treatment, taken medications or used an inhaler for emphysema? (Y/N).....  **RDF21A**

22) In the past 12 months, have you been newly diagnosed by a doctor or other health professional with COPD (chronic obstructive pulmonary disease)? .....  **RDF22**

- Yes ..... Y
- No ..... N → **Go to Item 23**
- Don't know ..... U → **Go to Item 23**

22a) In the past 12 months, have you received medical treatment, taken medications or used an inhaler for COPD? (Y/N).....  **RDF22A**

23) In the past 12 months, have you been newly diagnosed by a doctor or other health professional with sleep apnea?.....  **RDF23**

- Yes ..... Y
- No ..... N → **Go to Item 24**
- Don't know ..... U → **Go to Item 24**

23a) In the past 12 months, have you received any treatment for sleep apnea? (Y/N).....  **RDF23A**

- Yes ..... Y
- No ..... N → **Go to Item 24**

23b) Do you use a CPAP or BIPAP? (Y/N) .....  **RDF23B**

- Yes ..... Y
- No ..... N

23c) Did you have surgery for your sleep apnea? (Y/N) .....  **RDF23C**

- Yes ..... Y
- No ..... N

23d) Did you have some other treatment for your sleep apnea? (Y/N).....  **RDF23D**

- Yes ..... Y
- No ..... N → **Go to Item 24**

23e) Describe **RDF23E** \_\_\_\_\_

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24) In the past 12 months have you had:

24a) Any other chest illnesses? (Y/N) .....  **RDF24A**

If **Yes (Y)**, specify: **RDF24A1** \_\_\_\_\_

24b) Any chest operations? (Y/N) .....  **RDF24B**

If **Yes (Y)**, specify: **RDF24B1** \_\_\_\_\_

24c) Any chest injuries? (Y/N) .....  **RDF24C**

If **Yes (Y)**, specify: **RDF24C1** \_\_\_\_\_

**I am now going to ask you about some common environmental exposures.**

*[Do not read] Cigarette Smoking*

25) In the past 12 months have you smoked cigarettes? .....  **RDF25**

Yes ..... Y

No ..... N → **Go to Item 30**

26) Do you still smoke cigarettes as of one month ago? (Y/N) .....  **RDF26**

Yes ..... Y

No ..... N → **Go to Item 29**

27) Cigarettes smoke in the past 24 hours: (check here  if does not apply) **RDF27**

Approximately how many cigarettes have you smoked in the past

24 hours **RDF27A**

2 hours **RDF27B**

½ hour **RDF27C**

28) How many cigarettes do you smoke per day now? .....   **RDF28**

29) On average over the last 12 months, how many cigarettes did you smoke per day? .....   **RDF29**

30) Have you ever smoked menthol cigarettes? **RDF30**

Yes ..... Y

No ..... N → **Go to Item 31**

30a) For how long have you or did you smoke menthol cigarettes? .....   years **RDF30A**

31) What brands of cigarettes have you smoked?

a) **RDF31A** \_\_\_\_\_

b) **RDF31B** \_\_\_\_\_

c) **RDF31C** \_\_\_\_\_

d) **RDF31D** \_\_\_\_\_

e) **RDF31E** \_\_\_\_\_

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*[Do not read] Pipe Smoking*

32) In the past twelve months have you smoked a pipe regularly? .....  **RDF32**  
Yes ..... Y  
No ..... N → **Go to Item 36**

33) Do you smoke a pipe (as of one month ago)? (Y/N) .....  **RDF33**  
Yes ..... Y  
No ..... N → **Go to Item 36**

34) How much pipe tobacco do you smoke per day now? .....   **RDF34** oz per day

35) On average over the last 12 months, how many ounces of tobacco did you smoke per week? .....   **RDF35** oz per week

*[Do not read] Cigar Smoking*

36) In the past twelve months have you smoked cigars regularly? (**YES** means more than 1 cigar a week for one year at any time in your life) .....  **RDF36**  
Yes ..... Y  
No ..... N → **Go to Item 40**

37) Do you now smoke cigars (as of one month ago)? (Y/N) .....  **RDF37**  
Yes ..... Y →  
No ..... N → **Go to Item 39**

38) How many cigars smoke per day now? .....   .  **RDF38** per day

39) On average over the last 12 months, how many cigars did you smoke per week? .....   **RDF39** per week

**I'd now like to ask you about your second-hand smoke exposures.**

40) Which of the following best describes your approach to tobacco smoking in your home when you are in the house? .....  **RDF40**

Never allow smoking in home ..... 1  
Smoking is allowed only in certain rooms ..... 2  
Smoking is allowed in all rooms of your home ..... 3  
Refused ..... R  
Don't Know ..... D

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- 41) In the last 12 months, have you lived in the same household with someone who smoked tobacco products? .....   **RDF41**  
Yes ..... 1  
No ..... 0 → **Go to Item 45**  
Refused ..... R → **Go to Item 45**  
Don't know ..... D → **Go to Item 45**
- 42) Do you currently live in the same household with someone who smokes tobacco products? .....  **RDF42**  
Yes ..... Y  
No ..... N → **Go to Item 44**  
Refused ..... R → **Go to Item 44**  
Don't Know ..... D → **Go to Item 44**
- 43) How many people in your household currently smoke? .....   **RDF43**
- 44) In the last 12 months for how many months in total have you lived in the same household with someone else who smoke tobacco products? .....   **RDF44** months  
Refused ..... R  
Don't know ..... D

**I would now like to ask you about any smoke exposure that may have occurred in the past seven days.**

- 45) Has anyone smoked tobacco in your home during the past seven days? .....  **RDF45**  
Yes ..... Y  
No ..... N → **Go to Item 53**  
No Answer ..... U
- 46) During the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke at home? .....   **RDF46** hrs
- 47) During the past 7 days, did you enter a room in your home that was visibly smoky? .....  **RDF47**  
Yes ..... Y  
No ..... N  
No Answer ..... U
- 48) In the past 7 days, did you smell tobacco smoke in your home? (Y/N/U) .....  **RDF48**
- 49) During the past 7 days, did you experience red eyes or eye irritation? (Y/N/U) .....  **RDF49**
- 50) During the past 7 days, did you experience runny nose or nose irritation? (Y/N/U) .....  **RDF50**
- 51) During the past 7 days, did you experience coughing, wheezing or chest tightness? (Y/N/U) .....  **RDF51**

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- 52) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in your home? (Y/N/U) .....  **RDF52**
- 53) In the past 7 days, have you visited another person's home where someone was smoking tobacco products indoors? (Y/N/U) .....  **RDF53**  
**If N or U skip to 71**
- 54) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in another person's home? .....   **RDF54**  
hrs
- 55) During the past 7 days, did you enter a room in another person's home that was visibly smoky? (Y/N/U) .....  **RDF55**
- 56) In the past 7 days, did you smell tobacco smoke in another person's home? (Y/N/U) .....  **RDF56**
- 57) In the past 7 days, have you traveled by car or other vehicle with someone else who was smoking tobacco products? (Y/N/U) .....  **RDF57**  
**If N or U skip to 73**
- 58) In the past 7 days, how many hours did you spend traveling in a car while someone else was smoking tobacco? .....   **RDF58**  
hrs
- [Do not read] IF NOT A WORKER SKIP TO 68*
- 59) During the past 7 days, did anyone smoke tobacco inside your workplace, that is, while you were working indoors? (Y/N/U) .....  **RDF59**  
**If N or U skip to 75**
- 60) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke inside your workplace? .....   **RDF60**  
hrs
- 61) During the past 7 days, did you enter a room in your workplace that was visibly smoky? .....  **RDF61**
- 62) In the past 7 days, did you smell tobacco smoke in your workplace? .....  **RDF62**
- 63) Is there an outdoor area at your workplace where cigarette smokers routinely gather or congregate to smoke? (Y/N/U) .....  **RDF63**  
**If N or U skip to 66**
- 64) In the past 7 days, how many times did you walk through or past this area while others were smoking? (Y/N/U) .....  **RDF64**
- 65) During the past 7 days, how many hours in total did you spend in an outdoor smoking area while people were smoking? (Y/N/U) .....  **RDF65**
- 66) While walking through or past this area, did you smell smoke? (Y/N/U) .....  **RDF66**
- 67) In the past 7 days, how many hours did you spend near coworkers who were smoking tobacco outdoors? .....  **RDF67**



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82) On average, in the last 12 months about how many joints per week do (did) you smoke? .....  **RDF82**

83) On average, in the last 12 months about how many pipes per week do (did) you smoke? .....  **RDF83**

84) How many hours per day do you spend outdoors?

a) In spring.....  hrs **RDF84A**

b) In summer.....  hrs **RDF84B**

c) In fall .....  hrs **RDF84C**

d) In winter.....  hrs **RDF84D**

85) On average, how many hours per day do you spend in your home? .....  hrs **RDF85**

a) Do you have a central air conditioner? .....  **RDF85A**

Yes ..... Y

No ..... N → **Go to Item 85c**

b) How many months out of the year do you use it? .....  **RDF85B**

c) Do you have a room air conditioner? .....  **RDF85C**

Yes ..... Y

No ..... N → **Go to Item 85e**

d) How many months out of the year do you use it? .....  **RDF85D**

e) What kind of range or stove do you have? .....  **RDF85E**

Gas ..... G

Electric..... E

Other..... O

Specify **RDF85E1** \_\_\_\_\_

f) Does your range or stove have ventilation to the outdoors? .....  **RDF85F**

Yes ..... Y

No ..... N

Unknown..... U

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g) What is the main type of heating you use in your house? .....   **RDF85G**

- Radiator ..... 1 → **Go to Item 85i**
- Forced Air ..... 2 → **Go to Item 85h**
- Wood stove ..... 3 → **Go to Item 85i**
- Fireplace ..... 4 → **Go to Item 85i**
- Other ..... 5 → **Go to Item 85i**

h) What is the main type of heating fuel used in your house? .....   **RDF85H**

- Electric ..... 1
  - Natural Gas ..... 2
  - Oil ..... 3
  - Coal ..... 4
  - Wood ..... 5
  - Other ..... 6
- Specify **RDF85H1** \_\_\_\_\_

i) How many months out of the year do you use the main type of heating in your house? .....   **RDF85I**

j) Are there any other sources of heat? (check all that apply)

- Radiator .....  **RDF85J1**
- Forced Air .....  **RDF85J2**
- Wood stove .....  **RDF85J3**
- Fireplace .....  **RDF85J4**
- Other .....  **RDF85J5**

86) How much time per day do you spend commuting in traffic to work in total (i.e. both ways)?  **RDF86**

- None ..... 1
- 1-30 minutes ..... 2
- 30-60 minutes ..... 3
- More than 60 minutes (1 hour) ..... 4
- More than 120 minutes (2 hours) ..... 5

a) How many days per week do you commute to work? .....  **RDF86A**







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**These next questions relate to respiratory conditions**

- 16) Have you ever had asthma? .....  **RDS16**  
Yes ..... Y  
No ..... N → **Go to Item 17**  
Don't know ..... U → **Go to Item 17**
- 16a) At about what age did it start? .....   **RDS16A**  
 As a child; age not known (Check is appropriate) **RDS16A1**
- 16b) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS16B**
- 16c) Do you still have it? (Y/N/U) .....  **RDS16C**
- 16d) If you no longer have it, at what age did it stop? .....   **RDS16D**  
 As a child; age not known (Check is appropriate) **RDS16D1**
- 16e) In the past 12 months, have you received medical treatment, take medications or used an inhaler for asthma? (Y/N) .....  **RDS16E**
- 17) Have you ever had any hay fever (allergy involving the nose and/or eyes)? .....  **RDS17**  
Yes ..... Y  
No ..... N → **Go to Item 18**  
Don't know ..... U → **Go to Item 18**
- 17a) At about what age did it start? .....   **RDS17A**  
 As a child; age not known (Check is appropriate) **RDS17A1**
- 17b) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS17B**
- 17c) Do you still have it? (Y/N/U) .....  **RDS17C**
- 17d) If you no longer have it, at what age did it stop? .....   **RDS17D**  
 As a child; age not known (Check is appropriate) **RDS17D1**
- 17e) In the past 12 months, have you received medical treatment, take medications or used a nasal spray for hay fever? (Y/N) .....  **RDS17E**
- 18) Have you ever had an attack of bronchitis? .....  **RDS18**  
Yes ..... Y  
No ..... N → **Go to Item 19**  
Don't know ..... U → **Go to Item 19**
- 18a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS18A**
- 18b) At about what age did you first have bronchitis? .....   **RDS18B**  
 As a child; age not known (Check is appropriate) **RDS18B1**
- 18c) How many time have you had bronchitis? .....   times **RDS18C**

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19) Have you ever had pneumonia or bronchopneumonia?.....  **RDS19**

Yes ..... Y

No ..... N → **Go to Item 20**

Don't know ..... U → **Go to Item 20**

19a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS19A**

19b) At about what age did you first have pneumonia or bronchopneumonia? .....   **RDS19B**

As a child; age not known (Check is appropriate) **RDS19B1**

**RDS19C**

19c) How many time have you had pneumonia or bronchopneumonia?.....   times

20) Have you ever had chronic bronchitis?.....  **RDS20**

Yes ..... Y

No ..... N → **Go to Item 21**

Don't know ..... U → **Go to Item 21**

20a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS20A**

20b) At about what age did it start?.....   **RDS20B**

20c) Do you still have it? (Y/N/U) .....  **RDS20C**

20d) In the past 12 months, have you received medical treatment, take medications or used a  
inhaler for chronic bronchitis? (Y/N).....  **RDS20D**

21) Have you ever had emphysema? .....  **RDS21**

Yes ..... Y

No ..... N → **Go to Item 22**

Don't know ..... U → **Go to Item 22**

21a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS21A**

21b) At about what age did it start?.....   **RDS21B**

21c) Do you still have it? (Y/N/U) .....  **RDS21C**

21d) In the past 12 months, have you received medical treatment, take medications or used a  
inhaler for emphysema? (Y/N) .....  **RDS21D**

22) Have you ever had COPD (chronic obstructive pulmonary disease)? .....  **RDS22**

Yes ..... Y

No ..... N → **Go to Item 23**

Don't know ..... U → **Go to Item 23**

22a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS22A**

22b) At about what age did it start?.....   **RDS22B**

22c) Do you still have it? (Y/N/U) .....  **RDS22C**

22d) In the past 12 months, have you received medical treatment, take medications or used a  
inhaler for COPD? (Y/N).....  **RDS22D**

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23) Have you ever had sleep apnea? .....  **RDS23**

Yes ..... Y  
No ..... N → **Go to Item 24**  
Don't know ..... U → **Go to Item 24**

23a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS23A**

23b) At about what age did it start? .....   **RDS23B**

23c) Do you still have it? (Y/N/U) .....  **RDS23C**

23d) In the past 12 months, have you received any treatment for sleep apnea? (Y/N) .....  **RDS23D**

24) Have you ever had:

24a) Any other chest illnesses? (Y/N) .....  **RDS24A**

If **Yes (Y)**, specify: **RDS24A1** \_\_\_\_\_

24b) Any chest operations? (Y/N) .....  **RDS24B**

If **Yes (Y)**, specify: **RDS24B1** \_\_\_\_\_

24c) Any chest injuries? (Y/N) .....  **RDS24C**

If **Yes (Y)**, specify: **RDS24C1** \_\_\_\_\_

**I'd now like to ask you about your family history or respiratory disease.**

25) Were either of you natural parents told by a doctor they had a chronic lung condition such as:

	Father			Mother		
	YES	NO	Don't Know	YES	NO	Don't Know
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B1</b>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B2</b>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A3</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B3</b>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A4</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B4</b>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A5</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B5</b>

26) Were either of your natural parents ever a cigarette smoker?

Father:  Yes  No  Don't know **RDS26A**

Mother:  Yes  No  Don't know **RDS26B**

**I am now going to ask you about some common environmental exposures.**

*[Do not read] Cigarette Smoking*

27) Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes of 12 oz. of tobacco in a lifetime of less than 1 cigarette a day for one year at any time in your life) .....  **RDS27**

Yes ..... Y  
No ..... N → **Go to Item 34**

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28) How old were you when you first started regular cigarette smoking? ..... 

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**RDS28**

29) Do you smoke cigarettes (as of one month ago)? (Y/N)..... 

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**RDS29**

Yes ..... Y → **Go to Item 30**

No ..... N → **Go to Item 31**

30) How many cigarettes do you smoke per day now? ..... 

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**RDS30**

31) How old were you when you completely stopped smoking? ..... 

--	--

 yrs old **RDS31**

32) On average of the entire time you smoked, how many cigarettes did you smoke per day? ..... 

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 per day **RDS32**

33) Cigarettes smoke in the past 24 hours: (check here  if does not apply) **RDS33**

Approximately how many cigarettes have you smoked in the past

--	--

 in 24 hours **RDS33A**

--	--

 in 2 hours **RDS33B**

--	--

 in ½ hour **RDS33C**

*[Do not read] Pipe Smoking*

34) Have you ever smoked a pipe regularly? (**YES** means more than 12 oz of tobacco in a lifetime)..... 

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**RDS34**

Yes ..... Y

No ..... N → **Go to Item 40**

35) How old were you when you first started to smoke a pipe regularly? ..... 

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**RDS35**

36) Do you smoke a pipe (as of one month ago)? (Y/N) ..... 

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**RDS36**

Yes ..... Y → **Go to Item 37**

No ..... N → **Go to Item 38**

37) How much pipe tobacco do you smoke per day now? ..... 

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 oz per day **RDS37**

38) How old were you when you completely stopped smoking a pipe? ..... 

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 yrs old **RDS38**

39) On average of the entire time you smoked a pipe, how many ounces of tobacco did you smoke per week?..... 

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 oz per week **RDS39**

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*[Do not read] Cigar Smoking*

40) Have you ever smoked cigars regularly? (**YES** means more than 1 cigar a week for one year at any time in your life) .....  **RDS40**

Yes ..... Y  
No ..... N → **Go to Item 46**

41) How old were you when you first started to smoke cigars regularly? .....   **RDS41**

42) Do you now smoke cigars (as of one month ago)? (Y/N) .....  **RDS42**

Yes ..... Y → **Go to Item 43**  
No ..... N → **Go to Item 44**

43) How many cigars smoke per day now? .....   **RDS43**  
per day

44) How old were you when you completely stopped smoking cigars? .....   **RDS44**  
yrs old

45) On average of the entire time you smoked cigars, how many cigars did you smoke per week? .....   **RDS45**  
per week

**I'd now like to ask you about your second-hand smoke exposures.**

46) Which of the following best describes your approach to tobacco smoking in your home when you are in the house? .....  **RDS46**

- Never allow smoking in home ..... 1
- Smoking is allowed only in certain rooms ..... 2
- Smoking is allowed in all rooms of your home ..... 3
- Refused ..... R
- Don't Know ..... D

47) For how many years has this been your approach to smoking in you home? .....   **RDS47A**  
yrs

Refused ..... R **RDS47B**  
Don't Know ..... D

48) Do you currently live in the same household with someone who smokes tobacco products? .....  **RDS48**

Yes ..... Y → **Go to Item 50**  
No ..... N → **Go to Item 49**  
Refused ..... R → **Go to Item 52**  
Don't Know ..... D → **Go to Item 52**

49) Since age 18, have you ever lived in the same household with someone who smoked tobacco products? .....   **RDS49**  
yrs

Yes ..... 1 → **Go to Item 51**  
No ..... 0 → **Go to Item 52**

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Refused..... R → **Go to Item 52**  
Don't know..... D → **Go to Item 52**

50) How many people in your household smoke? .....   **RDS50**

51) Since age 18, for how many years in total have you lived in the same household with someone else who smoke tobacco products? .....   yrs **RDS51A**

Refused..... R **RDS51B**  
Don't know..... D

52) Growing up until age 18, were there any adults in your household who smoked at home? .....  **RDS52**

Yes ..... Y  
No ..... N → **Go to Item 54**  
Refused..... R → **Go to Item 54**  
Don't Know ..... D → **Go to Item 54**

53) Was this your father, your mother, or someone else? (*check all that apply*)

Father.....  **RDS53FATHERCBI**  
Mother.....  → **Answer Item 54** **RDS53MOTHERCBI**  
Other .....  **RDS53OTHERCBI**  
Refused.....  **RDS53REFUSED CBI**  
Don't Know .....  **RDS53NOTKNOWCBI**

54) Did your mother smoke cigarettes when she was pregnant with you before you were born? .....  **RDS55**

Yes ..... Y  
No..... N  
Refused..... R  
Don't know..... D

55) Growing up until age 18, for how many years in total did you live in the same household with someone else who smoked tobacco products? .....   yrs **RDS55A**

Refused..... R **RDS55B**  
Don't Know..... D

**I would now like to ask you about any smoke exposure that may have occurred in the past seven days.**

56) Has anyone smoked tobacco in your home during the past seven days? .....  **RDS56**

Yes ..... Y  
No..... N → **Go to Item 64**  
No Answer..... U

57) During the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke at home? .....   hrs **RDS57**



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58) During the past 7 days, did you enter a room in your home that was visibly smoky? .....  **RDS58**

Yes ..... Y  
No ..... N  
No Answer ..... U

59) In the past 7 days, did you smell tobacco smoke in your home? (Y/N/U) .....  **RDS59**

60) During the past 7 days, did you experience red eyes or eye irritation? (Y/N/U) .....  **RDS60**

61) During the past 7 days, did you experience runny nose or nose irritation? (Y/N/U) .....  **RDS61**

62) During the past 7 days, did you experience coughing, wheezing or chest tightness? (Y/N/U) .....  **RDS62**

63) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in your home? (Y/N/U) .....  **RDS63**

64) In the past 7 days, have you visited another person's home where someone was smoking tobacco products indoors? (Y/N/U) .....  **RDS64**  
If N or U skip to 66

65) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in another person's home? .....   **RDS65** hrs

66) During the past 7 days, did you enter a room in another person's home that was visibly smoky? (Y/N/U) .....  **RDS66**

67) In the past 7 days, did you smell tobacco smoke in another person's home? (Y/N/U) .....  **RDS67**

*[Do not read] Skip to Question 72* **RDS68-RDS71 removed 08/02/11**

72) In the past 7 days, have you traveled by car or other vehicle with someone else who was smoking tobacco products? (Y/N/U) .....  **RDS72**  
If N or U skip to 78

73) In the past 7 days, how many hours did you spend traveling in a car while someone else was smoking tobacco? .....   **RDS73** hrs

*[Do not read] Skip to Question 78* **RDS74-RDS77 removed 08/02/11**

*[Do not read] IF NOT A WORKER SKIP TO 102*

78) During the past 7 days, did anyone smoke tobacco inside your workplace, that is, while you were working indoors? (Y/N/U) .....  **RDS78**  
If N or U skip to 80

79) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke inside your workplace? .....   **RDS79** hrs

80) During the past 7 days, did you enter a room in your workplace that was visibly smoky? .....  **RDS80**

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81) In the past 7 days, did you smell tobacco smoke in your workplace? .....  **RDS81**

*[Do not read] Skip to Question 86* **RDS82-RDS85 removed 08/02/11**

86) Is there an outdoor area at your workplace where cigarette smokers routinely gather or  
congregate to smoke? (Y/N/U) .....  **RDS86**  
**If N or U skip to 95**

87) In the past 7 days, how many times did you walk through or past this area while others were  
smoking? (Y/N/U) .....  **RDS87**

88) During the past 7 days, how many hours in total did you spend in an outdoor smoking area while  
people were smoking? (Y/N/U) .....  **RDS88**

89) While walking through or past this area, did you smell smoke? (Y/N/U) .....  **RDS89**

*[Do not read] Skip to Question 95* **RDS90-RDS94 removed 08/02/11**

95) In the past 7 days, how many hours did you spend near coworkers who were smoking tobacco outdoors?  **RDS95**

96) During the past 7 days, did you smell tobacco smoke while working outdoors? .....  **RDS96**

*[Do not read] Skip to Question 101* **RDS97-RDS100 removed 08/02/11**

101) In the past seven days, have you been at an outdoor location (besides work) where someone  
was smoking tobacco products outside? (Y/N/U) .....  **RDS101**  
**If N or U skip to 103**

102) Where was this location? **RDS102** \_\_\_\_\_

103) During the past 7 days, did you smell tobacco smoke in this outdoor location? (Y/N/U) .....  **RDS103**  
**If N or U skip to 109**

104) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke  
this outdoor location? .....   hrs **RDS104**

*[Do not read] Skip to Question 109* **RDS105-RDS108 removed 08/02/11**

109) In the past seven days or nights, were you in a bar, nightclub, cocktail lounge, sports arena, or  
concert hall where someone else was smoking tobacco products? (Y/N/U) .....  **RDS109**  
**If N or U skip to 111**

110) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke  
in a bar or other place of entertainment? .....   hrs **RDS110**

111) During the past 7 days, did you enter a room in a bar or other place of entertainment that was  
visibly smoky? (Y/N/U) .....  **RDS111**

112) In the past 7 days, did you smell tobacco smoke in a bar or other place of entertainment? .....  **RDS112**

*[Do not read] Skip to Question 117* **RDS113-RDS116 removed 08/02/11**

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**You answered that you were exposed to someone else's tobacco smoke in a bar or other place of entertainment. During the past 7 days, did you experience any of the following after this exposure**

117) I have asked you about exposure to someone else's tobacco some in your home, friend's home, work, outdoor locations, and bars or nightclubs. In the past 7 days, was there any other location where you were exposed to tobacco smoke? (Y/N/U) .....  **RDS117**  
**If N or U skip to 124**

118) Where was this location? (Y/N/U).....  **RDS118**

119) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in this location? (Y/N/U).....  **RDS119**

[Do not read] Skip to Question 124 **RDS120-RDS123 removed 08/02/11**

**I would now like to ask you about any smoke exposure that may have occurred as a result of marijuana use. Please remember that all information that you give us is confidential, and only certified SPIROMICS personnel will have access to this information.**

124) Have you ever smoked marijuana (cannabis, pot, or hashish)? .....  **RDS124**  
Yes ..... Y  
No ..... N → **Go to END**

125) Have you ever smoked marijuana regularly (five times or more in a given year)? .....  **RDS125**  
Yes ..... Y  
No ..... N

126) On average over the entire time that you smoke(d) about how many joints per week do (did) you smoke? .....   **RDS126**

127) On average over the entire time that you smoke(d) about how many pipes per week do (did) you smoke? .....   **RDS127**

128) How many years have you smoked pot/marijuana? .....   yrs **RDS128**

[Do not read] Skip to Question 130

130) When was the last time you smoked marijuana? .....  **RDS130**  
In the last week..... 1  
In the last month..... 2  
In the last six months ..... 3  
In the last 12 months..... 4  
More than 12 months ago ..... 5  
Don't know..... 6  
Declines to answer..... 7

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**These next questions relate to respiratory conditions**

- 16) Have you ever had asthma? .....  **RDS16**  
Yes ..... Y  
No ..... N → **Go to Item 17**  
Don't know ..... U → **Go to Item 17**
- 16a) At about what age did it start? .....   **RDS16A**  
 As a child; age not known (Check is appropriate) **RDS16A1**
- 16b) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS16B**
- 16c) Do you still have it? (Y/N/U) .....  **RDS16C**
- 16d) If you no longer have it, at what age did it stop? .....   **RDS16D**  
 As a child; age not known (Check is appropriate) **RDS16D1**
- 16e) In the past 12 months, have you received medical treatment, take medications or used an inhaler for asthma? (Y/N) .....  **RDS16E**
- 17) Have you ever had any hay fever (allergy involving the nose and/or eyes)? .....  **RDS17**  
Yes ..... Y  
No ..... N → **Go to Item 18**  
Don't know ..... U → **Go to Item 18**
- 17a) At about what age did it start? .....   **RDS17A**  
 As a child; age not known (Check is appropriate) **RDS17A1**
- 17b) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS17B**
- 17c) Do you still have it? (Y/N/U) .....  **RDS17C**
- 17d) If you no longer have it, at what age did it stop? .....   **RDS17D**  
 As a child; age not known (Check is appropriate) **RDS17D1**
- 17e) In the past 12 months, have you received medical treatment, take medications or used a nasal spray for hay fever? (Y/N) .....  **RDS17E**
- 18) Have you ever had an attack of bronchitis? .....  **RDS18**  
Yes ..... Y  
No ..... N → **Go to Item 19**  
Don't know ..... U → **Go to Item 19**
- 18a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS18A**
- 18b) At about what age did you first have bronchitis? .....   **RDS18B**  
 As a child; age not known (Check is appropriate) **RDSB1** **RDS18C**
- 18c) How many time have you had bronchitis? .....   times

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19) Have you ever had pneumonia or bronchopneumonia? .....  **RDS19**

Yes ..... Y

No ..... N → **Go to Item 20**

Don't know ..... U → **Go to Item 20**

19a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS19A**

19b) At about what age did you first have pneumonia or bronchopneumonia? .....   **RDS19B**

As a child; age not known (Check is appropriate) **RDS19B1**

19c) How many time have you had pneumonia or bronchopneumonia? .....   times **RDS19C**

20) Have you ever had chronic bronchitis? .....  **RDS20**

Yes ..... Y

No ..... N → **Go to Item 21**

Don't know ..... U → **Go to Item 21**

20a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS20A**

20b) At about what age did it start? .....   **RDS20B**

20c) Do you still have it? (Y/N/U) .....  **RDS20C**

20d) In the past 12 months, have you received medical treatment, take medications or used a inhaler for chronic bronchitis? (Y/N) .....  **RDS20D**

21) Have you ever had emphysema? .....  **RDS21**

Yes ..... Y

No ..... N → **Go to Item 22**

Don't know ..... U → **Go to Item 22**

21a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS21A**

21b) At about what age did it start? .....   **RDS21B**

21c) Do you still have it? (Y/N/U) .....  **RDS21C**

21d) In the past 12 months, have you received medical treatment, take medications or used a inhaler for emphysema? (Y/N) .....  **RDS21D**

22) Have you ever had COPD (chronic obstructive pulmonary disease)? .....  **RDS22**

Yes ..... Y

No ..... N → **Go to Item 23**

Don't know ..... U → **Go to Item 23**

22a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS22A**

22b) At about what age did it start? .....   **RDS22B**

22c) Do you still have it? (Y/N/U) .....  **RDS22C**

22d) In the past 12 months, have you received medical treatment, take medications or used a inhaler for COPD? (Y/N) .....  **RDS22D**



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23) Have you ever had sleep apnea? .....  **RDS23**

Yes ..... Y  
No ..... N → **Go to Item 24**  
Don't know ..... U → **Go to Item 24**

23a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS23A**

23b) At about what age did it start? .....   **RDS23B**

23c) Do you still have it? (Y/N/U) .....  **RDS23C**

23d) In the past 12 months, have you received any treatment for sleep apnea? (Y/N) .....  **RDS23D**

24) Have you ever had:

24a) Any other chest illnesses? (Y/N) .....  **RDS24A**

If **Yes (Y)**, specify: **RDS24A1** \_\_\_\_\_

24b) Any chest operations? (Y/N) .....  **RDS24B**

If **Yes (Y)**, specify: **RDS24B1** \_\_\_\_\_

24c) Any chest injuries? (Y/N) .....  **RDS24C**

If **Yes (Y)**, specify: **RDS24C1** \_\_\_\_\_

**I'd now like to ask you about your family history or respiratory disease.**

25) Were either of you natural parents told by a doctor they had a chronic lung condition such as:

	Father			Mother		
	YES	NO	Don't Know	YES	NO	Don't Know
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B1</b>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B2</b>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A3</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B3</b>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A4</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B4</b>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A5</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B5</b>

26) Were either of your natural parents ever a cigarette smoker?

Father:  Yes  No  Don't know **RDS26A**  
Mother:  Yes  No  Don't know **RDS26B**

**I am now going to ask you about some common environmental exposures.**

*[Do not read] Cigarette Smoking*

27) Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes of 12 oz. of tobacco in a lifetime of less than 1 cigarette a day for one year at any time in your life) .....  **RDS27**

Yes ..... Y  
No ..... N → **Go to Item 34**

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28) How old were you when you first started regular cigarette smoking? ..... 

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**RDS28**

29) Do you smoke cigarettes (as of one month ago)? (Y/N)..... 

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**RDS29**

Yes ..... Y → **Go to Item 30**

No ..... N → **Go to Item 31**

30) How many cigarettes do you smoke per day now? ..... 

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**RDS30**

31) How old were you when you completely stopped smoking? ..... 

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 yrs old **RDS31**

32) On average of the entire time you smoked, how many cigarettes did you smoke per day? ..... 

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 per day **RDS32**

33) Cigarettes smoke in the past 24 hours: (check here  if does not apply) **RDS33**

Approximately how many cigarettes have you smoked in the past

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 in 24 hours **RDS33A**

--	--

 in 2 hours **RDS33B**

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 in ½ hour **RDS33C**

*[Do not read] Pipe Smoking*

34) Have you ever smoked a pipe regularly? (**YES** means more than 12 oz of tobacco in a lifetime)..... 

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**RDS34**

Yes ..... Y

No ..... N → **Go to Item 40**

35) How old were you when you first started to smoke a pipe regularly?..... 

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**RDS35**

36) Do you smoke a pipe (as of one month ago)? (Y/N) ..... 

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**RDS36**

Yes ..... Y → **Go to Item 37**

No ..... N → **Go to Item 38**

37) How much pipe tobacco do you smoke per day now? ..... 

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 oz per day **RDS37**

38) How old were you when you completely stopped smoking a pipe? ..... 

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 yrs old **RDS38**

39) On average of the entire time you smoked a pipe, how many ounces of tobacco did you smoke per week?..... 

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 oz per week **RDS39**

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*[Do not read] Cigar Smoking*

40) Have you ever smoked cigars regularly? (**YES** means more than 1 cigar a week for one year at any time in your life) .....  **RDS40**

Yes ..... Y  
No ..... N → **Go to Item 46**

41) How old were you when you first started to smoke cigars regularly? .....   **RDS41**

42) Do you now smoke cigars (as of one month ago)? (Y/N) .....  **RDS42**

Yes ..... Y → **Go to Item 43**  
No ..... N → **Go to Item 44**

43) How many cigars smoke per day now? .....   per day **RDS43**

44) How old were you when you completely stopped smoking cigars? .....   yrs old **RDS44**

45) On average of the entire time you smoked cigars, how many cigars did you smoke per week? .....   per week **RDS45**

**I'd now like to ask you about your second-hand smoke exposures.**

46) Which of the following best describes your approach to tobaccos smoking your home when you are in the house? .....  **RDS46**

- Never allow smoking in home ..... 1
- Smoking is allowed only in certain rooms ..... 2
- Smoking is allowed in all rooms of your home ..... 3
- Refused ..... R
- Don't Know ..... D

47) For how many years has this been your approach to smoking in you home? .....   yrs **RDS47A**

Refused ..... R **RDS47B**  
Don't Know ..... D

48) Do you currently live in the same household with someone who smokes tobacco products? .....  **RDS48**

Yes ..... Y → **Go to Item 50**  
No ..... N → **Go to Item 49**  
Refused ..... R → **Go to Item 52**  
Don't Know ..... D → **Go to Item 52**

49) Since age 18, have you ever lived in the same household with someone who smoked tobacco products? .....   yrs **RDS49**

Yes ..... 1 → **Go to Item 51**  
No ..... 0 → **Go to Item 52**

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Refused..... R → **Go to Item 52**  
Don't know..... D → **Go to Item 52**

50) How many people in your household smoke? .....   **RDS50**

51) Since age 18, for how many years in total have you lived in the same household with  
someone else who smoke tobacco products? .....   yrs **RDS51A**

Refused..... R **RDS51B**  
Don't know..... D

52) Growing up until age 18, were there any adults in your household who smoked at home? .....  **RDS52**

Yes..... Y  
No..... N → **Go to Item 54**  
Refused..... R → **Go to Item 54**  
Don't Know ..... D → **Go to Item 54**

53) Was this your father, your mother, or someone else? (*check all that apply*)

Father.....  **RDS53FATHERCBI**  
Mother.....  → **Answer Item 54** **RDS53MOTHERCBI**  
Other .....  **RDS53OTHERCBI**  
Refused.....  **RDS53REFUSED CBI**  
Don't Know .....  **RDS53NOTKNOWCBI**

54) Did your mother smoke cigarettes when she was pregnant with you before you were born? .....  **RDS55**

Yes ..... Y  
No..... N  
Refused..... R  
Don't know..... D

55) Growing up until age 18, for how many years in total did you live in the same household with  
someone else who smoked tobacco products? .....   yrs **RDS55A**

Refused..... R **RDS55B**  
Don't Know ..... D

**I would now like to ask you about any smoke exposure that may have occurred in the past seven days.**

56) Has anyone smoked tobacco in your home during the past seven days? .....  **RDS56**

Yes ..... Y  
No..... N → **Go to Item 64**  
No Answer..... U

57) During the past 7 days, how many hours in total were you exposed to someone else's  
tobacco smoke at home? .....   hrs **RDS57**

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58) During the past 7 days, did you enter a room in your home that was visibly smoky? .....  **RDS58**  
Yes ..... Y  
No ..... N  
No Answer ..... U

59) In the past 7 days, did you smell tobacco smoke in your home? (Y/N/U) .....  **RDS59**

60) During the past 7 days, did you experience red eyes or eye irritation? (Y/N/U).....  **RDS60**

61) During the past 7 days, did you experience runny nose or nose irritation? (Y/N/U).....  **RDS61**

62) During the past 7 days, did you experience coughing, wheezing or chest tightness? (Y/N/U) .....  **RDS62**

63) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in your home? (Y/N/U) .....  **RDS637**

64) In the past 7 days, have you visited another person's home where someone was smoking tobacco products indoors? (Y/N/U).....  **RDS64**  
**If N or U skip to 66**

65) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in another person's home? .....   **RDS65** hrs

66) During the past 7 days, did you enter a room in another person's home that was visibly smoky? (Y/N/U).....  **RDS66**

67) In the past 7 days, did you smell tobacco smoke in another person's home? (Y/N/U) .....  **RDS67**

**You answered that you were exposed to someone else's tobacco smoke in another person's home. During the past 7 days, did you experience any of the following after this exposure?**

If No to Q64, Q66, and Q67, skip questions 68-71:

68) Red eyes or eye irritations? (Y/N/U) .....  **RDS68**

69) Runny nose or nose irritation? (Y/N/U).....  **RDS69**

70) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS70**

71) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in another person's home? (Y/N/U).....  **RDS71**

72) In the past 7 days, have you traveled by car or other vehicle with someone else who was smoking tobacco products? (Y/N/U) .....  **RDS72**  
**If N or U skip to 78**

73) In the past 7 days, how many hours did you spend traveling in a car while someone else was smoking tobacco? .....   **RDS73** hrs

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**You answered that you were exposed to someone else's tobacco smoke while traveling by car. During the pas 7 days, did you experience any of the following after this exposure?**

If No to Q72, skip questions 74-77:

- 74) Red eyes or eye irritation? (Y/N/U).....  **RDS74**
- 75) Runny nose or nose irritation? (Y/N/U).....  **RDS75**
- 76) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS76**
- 77) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in a car? (Y/N/U).....  **RDS77**

*[Do not read] IF NOT A WORKER SKIP TO 102*

- 78) During the past 7 days, did anyone smoke tobacco inside your workplace, that is, while you were working indoors? (Y/N/U) .....  **RDS78**  
If N or U skip to 80
- 79) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke inside your workplace? .....   hrs **RDS79**
- 80) During the past 7 days, did you enter a room in your workplace that was visibly smoky? .....  **RDS80**
- 81) In the past 7 days, did you smell tobacco smoke in your workplace? .....  **RDS81**

**You answered that you were exposed to someone else's tobacco smoke in your workplace. During the past 7 days, did you experience any of the following after this exposure?**

If No to Q78, Q80, and Q81, skip questions 82-85:

- 82) Red eyes or eye irritation? (Y/N/U).....  **RDS82**
- 83) Runny nose or nose irritation? (Y/N/U).....  **RDS83**
- 84) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS84**
- 85) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in your workplace? (Y/N/U).....  **RDS85**
- 86) Is there an outdoor area at your workplace where cigarette smokers routinely gather or congregate to smoke? (Y/N/U).....  **RDS86**  
If N or U skip to 94
- 87) In the past 7 days, how many times did you walk through or past this area while others were smoking? (Y/N/U) .....  **RDS87**
- 88) During the past 7 days, how many hours in total did you spend in an outdoor smoking area while people were smoking? (Y/N/U) .....  **RDS88**

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89) While walking through or past this area, did you smell smoke? (Y/N/U) .....  **RDS89**

**In the past 7 days, did you walking through or past this area result in your experiencing any of the following:**

If No to Q86, skip questions 90-93:

90) Red eyes or eye irritation? (Y/N/U).....  **RDS90**

91) Runny nose or nose irritation? (Y/N/U).....  **RDS91**

92) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS92**

93) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after walking through or past this area? (Y/N/U).....  **RDS93**

94) Do your job duties directly involve working outdoors one or more hours per week? .....  **RDS94**

95) In the past 7 days, how many hours did you spend near coworkers who were smoking tobacco outdoors? .....  **RDS95**

96) During the past 7 days, did you smell tobacco smoke while working outdoors? .....  **RDS96**

**You answered that you were exposed to your coworker's tobacco smoke while working outdoors. During the past 7 days, did you experience any of the following after this exposure?**

If No to Q95 and Q96, skip questions 97-100:

97) Red eyes or eye irritation? (Y/N/U).....  **RDS97**

98) Runny nose or nose irritation? (Y/N/U).....  **RDS98**

99) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS99**

100) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke outside? (Y/N/U) .....  **RDS100**

101) In the past seven days, have you been at an outdoor location (besides work) where someone was smoking tobacco products outside? (Y/N/U).....  **RDS101**  
**If N or U skip to 103**

102) Where was this location? **RDS102** \_\_\_\_\_

103) During the past 7 days, did you smell tobacco smoke in this outdoor location? (Y/N/U) .....  **RDS103**  
**If N or U skip to 103**

104) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke this outdoor location? .....   hrs **RDS104**

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**During the past 7 days, did you experience any of the following after this outdoor exposure:**

If No to Q101 and Q103, skip questions 105-108:

- 105) Red eyes or eye irritation? (Y/N/U) .....  **RDS105**
- 106) Runny nose or nose irritation? (Y/N/U) .....  **RDS106**
- 107) Coughing, wheezing, or chest tightness? (Y/N/U) .....  **RDS107**
- 108) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in this outdoor location? (Y/N/U) .....  **RDS108**
- 109) In the past seven days or nights, were you in a bar, nightclub, cocktail lounge, sports arena, or concert hall where someone else was smoking tobacco products? (Y/N/U) .....  **RDS109**  
**If N or U skip to 111**
- 110) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in a bar or other place of entertainment? .....   **RDS110**  
hrs
- 111) During the past 7 days, did you enter a room in a bar or other place of entertainment that was visibly smoky? (Y/N/U) .....  **RDS111**
- 112) In the past 7 days, did you smell tobacco smoke in a bar or other place of entertainment? .....  **RDS112**

**You answered that you were exposed to someone else's tobacco smoke in a bar or other place of entertainment. During the past 7 days, did you experience any of the following after this exposure**

If No to Q109, Q111, and Q112. skip questions 113-116:

- 113) Red eyes or eye irritation? (Y/N/U) .....  **RDS113**
- 114) Runny nose or nose irritation? (Y/N/U) .....  **RDS114**
- 115) Coughing, wheezing, or chest tightness? (Y/N/U) .....  **RDS115**
- 116) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in a bar or other place of entertainment? (Y/N/U) .....  **RDS116**
- 117) I have asked you about exposure to someone else's tobacco smoke in your home, friend's home, work, outdoor locations, and bars or nightclubs. In the past 7 days, was there any other location where you were exposed to tobacco smoke? (Y/N/U) .....  **RDS117**  
**If N or U skip to end**
- 118) Where was this location? (Y/N/U) .....  **RDS118**
- 119) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in this location? (Y/N/U) .....  **RDS119**

**During the past 7 days, did you experience any of the following after this outdoor exposure:**



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- 120) Red eyes or eye irritation? (Y/N/U) .....  **RDS120**
- 121) Runny nose or nose irritation? (Y/N/U) .....  **RDS121**
- 122) Coughing, wheezing, or chest tightness? (Y/N/U) .....  **RDS122**
- 123) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in this location? (Y/N/U) .....  **RDS123**

**I would now like to ask you about any smoke exposure that may have occurred as a result of marijuana use. Please remember that all information that you give us is confidential, and only certified SPIROMICS personnel will have access to this information.**

- 124) Have you ever smoked marijuana (cannabis, pot, or hashish)? .....  **RDS124**  
Yes ..... Y  
No ..... N → **Go to END**
- 125) Have you ever smoked marijuana regularly (five times or more in a given year)? .....  **RDS125**  
Yes ..... Y  
No ..... N
- 126) On average over the entire time that you smoke(d) about how many joints per week do (did) you smoke? .....   **RDS126**
- 127) On average over the entire time that you smoke(d) about how many pipes per week do (did) you smoke? .....   **RDS127**
- 128) How many years have you smoked pot/marijuana? .....   yrs **RDS128**
- 129) Have you smoked marijuana in the last 12 months? .....  **RDS129**  
Yes ..... Y  
No ..... N





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**These next questions relate to respiratory conditions**

- 16) Have you ever had asthma? .....  **RDS16**  
Yes ..... Y  
No ..... N → **Go to Item 17**  
Don't know ..... U → **Go to Item 17**
- 16a) At about what age did it start? .....   **RDS16A**  
 As a child; age not known (Check is appropriate) **RDS16A1**
- 16b) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS16B**
- 16c) Do you still have it? (Y/N/U) .....  **RDS16C**
- 16d) If you no longer have it, at what age did it stop? .....   **RDS16D**  
 As a child; age not known (Check is appropriate) **RDS16D1**
- 16e) In the past 12 months, have you received medical treatment, take medications or used an inhaler for asthma? (Y/N) .....  **RDS16E**
- 17) Have you ever had any hay fever (allergy involving the nose and/or eyes)? .....  **RDS17**  
Yes ..... Y  
No ..... N → **Go to Item 18**  
Don't know ..... U → **Go to Item 18**
- 17a) At about what age did it start? .....   **RDS17A**  
 As a child; age not known (Check is appropriate) **RDS17A1**
- 17b) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS17B**
- 17c) Do you still have it? (Y/N/U) .....  **RDS17C**
- 17d) If you no longer have it, at what age did it stop? .....   **RDS17D**  
 As a child; age not known (Check is appropriate) **RDS17D1**
- 17e) In the past 12 months, have you received medical treatment, take medications or used a nasal spray for hay fever? (Y/N) .....  **RDS17E**
- 18) Have you ever had an attack of bronchitis? .....  **RDS18**  
Yes ..... Y  
No ..... N → **Go to Item 19**  
Don't know ..... U → **Go to Item 19**
- 18a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS18A**
- 18b) At about what age did you first have bronchitis? .....   **RDS18B**  
 As a child; age not known (Check is appropriate) **RDSB1**
- 18c) How many time have you had bronchitis? .....   times **RDS18C**

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19) Have you ever had pneumonia or bronchopneumonia?.....  **RDS19**

Yes ..... Y

No ..... N → **Go to Item 20**

Don't know ..... U → **Go to Item 20**

19a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS19A**

19b) At about what age did you first have pneumonia or bronchopneumonia? .....   **RDS19B**

As a child; age not known (Check is appropriate) **RDS19B1**

19c) How many time have you had pneumonia or bronchopneumonia?.....   times **RDS19C**

20) Have you ever had chronic bronchitis?.....  **RDS20**

Yes ..... Y

No ..... N → **Go to Item 21**

Don't know ..... U → **Go to Item 21**

20a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS20A**

20b) At about what age did it start?.....   **RDS20B**

20c) Do you still have it? (Y/N/U) .....  **RDS20C**

20d) In the past 12 months, have you received medical treatment, take medications or used a  
inhaler for chronic bronchitis? (Y/N).....  **RDS20D**

21) Have you ever had emphysema? .....  **RDS21**

Yes ..... Y

No ..... N → **Go to Item 22**

Don't know ..... U → **Go to Item 22**

21a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS21A**

21b) At about what age did it start?.....   **RDS21B**

21c) Do you still have it? (Y/N/U) .....  **RDS21C**

21d) In the past 12 months, have you received medical treatment, take medications or used a  
inhaler for emphysema? (Y/N) .....  **RDS21D**

22) Have you ever had COPD (chronic obstructive pulmonary disease)? .....  **RDS22**

Yes ..... Y

No ..... N → **Go to Item 23**

Don't know ..... U → **Go to Item 23**

22a) Was it diagnosed by a doctor or other health professional? (Y/N/U).....  **RDS22A**

22b) At about what age did it start?.....   **RDS22B**

22c) Do you still have it? (Y/N/U) .....  **RDS22C**

22d) In the past 12 months, have you received medical treatment, take medications or used a  
inhaler for COPD? (Y/N).....  **RDS22D**

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23) Have you ever had sleep apnea? .....  **RDS23**

Yes ..... Y  
No ..... N → **Go to Item 24**  
Don't know ..... U → **Go to Item 24**

23a) Was it diagnosed by a doctor or other health professional? (Y/N/U) .....  **RDS23A**

23b) At about what age did it start? .....   **RDS23B**

23c) Do you still have it? (Y/N/U) .....  **RDS23C**

23d) In the past 12 months, have you received any treatment for sleep apnea? (Y/N) .....  **RDS23D**

24) Have you ever had:

24a) Any other chest illnesses? (Y/N) .....  **RDS24A**

If **Yes (Y)**, specify: **RDS24A1** \_\_\_\_\_

24b) Any chest operations? (Y/N) .....  **RDS24B**

If **Yes (Y)**, specify: **RDS24B1** \_\_\_\_\_

24c) Any chest injuries? (Y/N) .....  **RDS24C**

If **Yes (Y)**, specify: **RDS24C1** \_\_\_\_\_

**I'd now like to ask you about your family history or respiratory disease.**

25) Were either of you natural parents told by a doctor they had a chronic lung condition such as:

	Father			Mother		
	YES	NO	Don't Know	YES	NO	Don't Know
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B1</b>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B2</b>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A3</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B3</b>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A4</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B4</b>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25A5</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>RDS25B5</b>

26) Were either of your natural parents ever a cigarette smoker?

Father:  Yes  No  Don't know **RDS26A**

Mother:  Yes  No  Don't know **RDS26B**

**I am now going to ask you about some common environmental exposures.**

*[Do not read] Cigarette Smoking*

27) Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes of 12 oz. of tobacco in a lifetime of less than 1 cigarette a day for one year at any time in your life) .....  **RDS27**

Yes ..... Y  
No ..... N → **Go to Item 34**

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28) How old were you when you first started regular cigarette smoking? .....   **RDS28**

29) Do you smoke cigarettes (as of one month ago)? (Y/N).....  **RDS29**

Yes ..... Y → **Go to Item 30**

No ..... N → **Go to Item 31**

30) How many cigarettes do you smoke per day now? .....   **RDS30**

31) How old were you when you completely stopped smoking? .....   **RDS31**  
yrs old

32) On average of the entire time you smoked, how many cigarettes did you smoke per day? .....   **RDS32**  
per day

33) Cigarettes smoke in the past 24 hours: (check here  if does not apply) **RDS33**

Approximately how many cigarettes have you smoked in the past

in 24 hours **RDS33A**

in 2 hours **RDS33B**

in ½ hour **RDS33C**

*[Do not read] Pipe Smoking*

34) Have you ever smoked a pipe regularly? (**YES** means more than 12 oz of tobacco in a lifetime).....  **RDS34**

Yes ..... Y

No ..... N → **Go to Item 40**

35) How old were you when you first started to smoke a pipe regularly? .....   **RDS35**

36) Do you smoke a pipe (as of one month ago)? (Y/N) .....  **RDS36**

Yes ..... Y → **Go to Item 37**

No ..... N → **Go to Item 38**

37) How much pipe tobacco do you smoke per day now? .....   **RDS37**  
oz per day

38) How old were you when you completely stopped smoking a pipe? .....   **RDS38**  
yrs old

39) On average of the entire time you smoked a pipe, how many ounces of tobacco did you smoke  
per week?.....   **RDS39**  
oz per week

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*[Do not read] Cigar Smoking*

40) Have you ever smoked cigars regularly? (**YES** means more than 1 cigar a week for one year at any time in your life) .....  **RDS40**

Yes ..... Y  
No ..... N → **Go to Item 46**

41) How old were you when you first started to smoke cigars regularly? .....   **RDS41**

42) Do you now smoke cigars (as of one month ago)? (Y/N) .....  **RDS42**

Yes ..... Y → **Go to Item 43**  
No ..... N → **Go to Item 44**

43) How many cigars smoke per day now? .....   **RDS43**  
per day

44) How old were you when you completely stopped smoking cigars? .....   **RDS44**  
yrs old

45) On average of the entire time you smoked cigars, how many cigars did you smoke per week? .....   **RDS45**  
per week

**I'd now like to ask you about your second-hand smoke exposures.**

46) Which of the following best describes your approach to tobaccos smoking your home when you are in the house? .....  **RDS46**

- Never allow smoking in home ..... 1
- Smoking is allowed only in certain rooms ..... 2
- Smoking is allowed in all rooms of your home ..... 3
- Refused ..... R
- Don't Know ..... D

47) For how many years has this been your approach to smoking in you home? .....   **RDS47A**  
yrs

Refused ..... R **RDS47B**  
Don't Know ..... D

48) Do you currently live in the same household with someone who smokes tobacco products? .....  **RDS48**

Yes ..... Y → **Go to Item 50**  
No ..... N → **Go to Item 49**  
Refused ..... R → **Go to Item 52**  
Don't Know ..... D → **Go to Item 52**

49) Since age 18, have you ever lived in the same household with someone who smoked tobacco products? .....   **RDS49**  
yrs

Yes ..... 1 → **Go to Item 51**  
No ..... 0 → **Go to Item 52**



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Refused..... R → **Go to Item 52**  
Don't know..... D → **Go to Item 52**

50) How many people in your household smoke? .....   **RDS50**

51) Since age 18, for how many years in total have you lived in the same household with  
someone else who smoke tobacco products? .....   yrs **RDS51A**

Refused..... R **RDS51B**  
Don't know..... D

52) Growing up until age 18, were there any adults in your household who smoked at home? .....  **RDS52**

Yes ..... Y  
No ..... N → **Go to Item 54**  
Refused..... R → **Go to Item 54**  
Don't Know ..... D → **Go to Item 54**

53) Was this your father, your mother, or someone else? (*check all that apply*)

Father.....  **RDS53FATHERCBI**  
Mother.....  → **Answer Item 54** **RDS53MOTHERCBI**  
Other.....  **RDS53OTHERCBI**  
Refused.....  **RDS53REFUSED CBI**  
Don't Know.....  **RDS53NOTKNOWCBI**

54) Did your mother smoke cigarettes when she was pregnant with you before you were born? .....  **RDS55**

Yes ..... Y  
No..... N  
Refused..... R  
Don't know..... D

55) Growing up until age 18, for how many years in total did you live in the same household with  
someone else who smoked tobacco products? .....   yrs **RDS55A**

Refused..... R **RDS55B**  
Don't Know..... D

**I would now like to ask you about any smoke exposure that may have occurred in the past seven days.**

56) Has anyone smoked tobacco in your home during the past seven days? .....  **RDS56**

Yes ..... Y  
No..... N → **Go to Item 64**  
No Answer..... U

57) During the past 7 days, how many hours in total were you exposed to someone else's  
tobacco smoke at home? .....   hrs **RDS57**

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58) During the past 7 days, did you enter a room in your home that was visibly smoky? .....  **RDS58**

Yes ..... Y  
No ..... N  
No Answer ..... U

59) In the past 7 days, did you smell tobacco smoke in your home? (Y/N/U) .....  **RDS59**

60) During the past 7 days, did you experience red eyes or eye irritation? (Y/N/U).....  **RDS60**

61) During the past 7 days, did you experience runny nose or nose irritation? (Y/N/U).....  **RDS61**

62) During the past 7 days, did you experience coughing, wheezing or chest tightness? (Y/N/U) .....  **RDS62**

63) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in your home? (Y/N/U) .....  **RDS637**

64) In the past 7 days, have you visited another person's home where someone was smoking tobacco products indoors? (Y/N/U).....  **RDS64**  
**If N or U skip to 66**

65) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in another person's home? .....   hrs **RDS65**

66) During the past 7 days, did you enter a room in another person's home that was visibly smoky? (Y/N/U).....  **RDS66**

67) In the past 7 days, did you smell tobacco smoke in another person's home? (Y/N/U) .....  **RDS67**

**You answered that you were exposed to someone else's tobacco smoke in another person's home. During the past 7 days, did you experience any of the following after this exposure?**

If No to Q64, Q66, and Q67, skip questions 68-71:

68) Red eyes or eye irritations? (Y/N/U) .....  **RDS68**

69) Runny nose or nose irritation? (Y/N/U).....  **RDS69**

70) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS70**

71) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in another person's home? (Y/N/U) .....  **RDS71**

72) In the past 7 days, have you traveled by car or other vehicle with someone else who was smoking tobacco products? (Y/N/U) .....  **RDS72**  
**If N or U skip to 73**

73) In the past 7 days, how many hours did you spend traveling in a car while someone else was smoking tobacco? .....   hrs **RDS73**

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**You answered that you were exposed to someone else's tobacco smoke while traveling by car. During the pas 7 days, did you experience any of the following after this exposure?**

If No to Q72, skip questions 74-77:

- 74) Red eyes or eye irritation? (Y/N/U).....  **RDS74**
- 75) Runny nose or nose irritation? (Y/N/U).....  **RDS75**
- 76) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS76**
- 77) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in a car? (Y/N/U).....  **RDS77**

*[Do not read] IF NOT A WORKER SKIP TO 102*

- 78) During the past 7 days, did anyone smoke tobacco inside your workplace, that is, while you were working indoors? (Y/N/U) .....  **RDS78**  
**If N or U skip to 80**
- 79) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke inside your workplace? .....   **RDS79** hrs
- 80) During the past 7 days, did you enter a room in your workplace that was visibly smoky? .....  **RDS80**
- 81) In the past 7 days, did you smell tobacco smoke in your workplace? .....  **RDS81**

**You answered that you were exposed to someone else's tobacco smoke in your workplace. During the past 7 days, did you experience any of the following after this exposure?**

If No to Q78, Q80, and Q81, skip questions 82-85:

- 82) Red eyes or eye irritation? (Y/N/U).....  **RDS82**
- 83) Runny nose or nose irritation? (Y/N/U).....  **RDS83**
- 84) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS84**
- 85) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in your workplace? (Y/N/U).....  **RDS85**
- 86) Is there an outdoor area at your workplace where cigarette smokers routinely gather or congregate to smoke? (Y/N/U) .....  **RDS86**  
**If N or U skip to 94**
- 87) In the past 7 days, how many times did you walk through or past this area while others were smoking? (Y/N/U) .....  **RDS87**
- 88) During the past 7 days, how many hours in total did you spend in an outdoor smoking area while people were smoking? (Y/N/U) .....  **RDS88**

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89) While walking through or past this area, did you smell smoke? (Y/N/U).....  **RDS89**

**In the past 7 days, did you walking through or past this area result in your experiencing any of the following:**

If No to Q86, skip questions 90-93:

90) Red eyes or eye irritation? (Y/N/U).....  **RDS90**

91) Runny nose or nose irritation? (Y/N/U).....  **RDS91**

92) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS92**

93) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after walking through or past this area? (Y/N/U).....  **RDS93**

94) Do your job duties directly involve working outdoors one or more hours per week? .....  **RDS94**

95) In the past 7 days, how many hours did you spend near coworkers who were smoking tobacco outdoors? .....  **RDS95**

96) During the past 7 days, did you smell tobacco smoke while working outdoors?.....  **RDS96**

**You answered that you were exposed to your coworker's tobacco smoke while working outdoors. During the past 7 days, did you experience any of the following after this exposure?**

If No to Q95 and Q96, skip questions 97-100:

97) Red eyes or eye irritation? (Y/N/U).....  **RDS97**

98) Runny nose or nose irritation? (Y/N/U).....  **RDS98**

99) Coughing, wheezing, or chest tightness? (Y/N/U).....  **RDS99**

100) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke outside? (Y/N/U) .....  **RDS100**

101) In the past seven days, have you been at an outdoor location (besides work) where someone was smoking tobacco products outside? (Y/N/U) .....  **RDS101**  
**If N or U skip to 103**

102) Where was this location? **RDS102** \_\_\_\_\_

103) During the past 7 days, did you smell tobacco smoke in this outdoor location? (Y/N/U) .....  **RDS103**  
**If N or U skip to 103**

104) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke this outdoor location?.....   hrs **RDS104**

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**During the past 7 days, did you experience any of the following after this outdoor exposure:**

If No to Q101 and Q103, skip questions 105-108:

- 105) Red eyes or eye irritation? (Y/N/U) .....  **RDS105**
- 106) Runny nose or nose irritation? (Y/N/U) .....  **RDS106**
- 107) Coughing, wheezing, or chest tightness? (Y/N/U) .....  **RDS107**
- 108) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in this outdoor location? (Y/N/U) .....  **RDS108**
- 109) In the past seven days or nights, were you in a bar, nightclub, cocktail lounge, sports arena, or concert hall where someone else was smoking tobacco products? (Y/N/U) .....  **RDS109**  
**If N or U skip to 111**
- 110) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in a bar or other place of entertainment? .....   **RDS110** hrs
- 111) During the past 7 days, did you enter a room in a bar or other place of entertainment that was visibly smoky? (Y/N/U) .....  **RDS111**
- 112) In the past 7 days, did you smell tobacco smoke in a bar or other place of entertainment? .....  **RDS112**

**You answered that you were exposed to someone else's tobacco smoke in a bar or other place of entertainment. During the past 7 days, did you experience any of the following after this exposure**

If No to Q109, Q111, and Q112. skip questions 113-116:

- 113) Red eyes or eye irritation? (Y/N/U) .....  **RDS113**
- 114) Runny nose or nose irritation? (Y/N/U) .....  **RDS114**
- 115) Coughing, wheezing, or chest tightness? (Y/N/U) .....  **RDS115**
- 116) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung problems after exposure to tobacco smoke in a bar or other place of entertainment? (Y/N/U) .....  **RDS116**
- 117) I have asked you about exposure to someone else's tobacco smoke in your home, friend's home, work, outdoor locations, and bars or nightclubs. In the past 7 days, was there any other location where you were exposed to tobacco smoke? (Y/N/U) .....  **RDS117**  
**If N or U skip to end**
- 118) Where was this location? (Y/N/U) .....  **RDS118**
- 119) In the past 7 days, how many hours in total were you exposed to someone else's tobacco smoke in this location? (Y/N/U) .....  **RDS119**

**During the past 7 days, did you experience any of the following after this outdoor exposure:**

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- 120) Red eyes or eye irritation? (Y/N/U) .....  **RDS120**
- 121) Runny nose or nose irritation? (Y/N/U) .....  **RDS121**
- 122) Coughing, wheezing, or chest tightness? (Y/N/U) .....  **RDS122**
- 123) In the past 7 days, did you take any extra handheld spray inhalers for breathing or lung  
problems after exposure to tobacco smoke in this location? (Y/N/U) .....  **RDS123**



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4a) Which inhaled steroid(s) have you used in the past 3 months?

- |   | Yes                      |   | <u>Puffs/day</u> | No                       |
|---|--------------------------|---|------------------|--------------------------|
| 1) Azmacort (triamcinolone) .....         | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A1A</u>  |                          |
| 2) Beclovent (beclomethasone).....        | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A2A</u>  |                          |
| 3) Vanceril (beclomethasone) .....        | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A3A</u>  |                          |
| <input type="checkbox"/> Regular Strength |                          |   |                  |                          |
| <input type="checkbox"/> Double Strength  |                          |   | <u>RMU04A3B</u>  |                          |
| 4) AeroBid (blunisolide).....             | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A4A</u>  |                          |
|   | Yes                      |   | <u>Puffs/Day</u> | No                       |
| 5) Flovent (fluticasone).....             | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A5A</u>  |                          |
| <input type="checkbox"/> 44 Aerosol       |                          |   | <u>RMU04A5B</u>  |                          |
| <input type="checkbox"/> 110 Aerosol      |                          |   |                  |                          |
| <input type="checkbox"/> 220 Aerosol      |                          |   |                  |                          |
| <input type="checkbox"/> 100 Diskus       |                          |   |                  |                          |
| <input type="checkbox"/> 250 Diskus       |                          |   |                  |                          |
| 6) Pulmicort (budesonide) .....           | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A6A</u>  |                          |
| <input type="checkbox"/> 90               |                          |   | <u>RMU04A6B</u>  |                          |
| <input type="checkbox"/> 180              |                          |   |                  |                          |
| 7) Qvar (beclomethasone).....             | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A7A</u>  |                          |
| <input type="checkbox"/> 40               |                          |   | <u>RMU04A7B</u>  |                          |
| <input type="checkbox"/> 80               |                          |   |                  |                          |
| 8) Advair (fluticasone/salmeterol) .....  | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A8A</u>  |                          |
| <input type="checkbox"/> 100/50           |                          |   | <u>RMU04A8B</u>  |                          |
| <input type="checkbox"/> 250/50           |                          |   |                  |                          |
| <input type="checkbox"/> 500/50           |                          |   |                  |                          |
| <input type="checkbox"/> HFA 45/21        |                          |   |                  |                          |
| <input type="checkbox"/> HFA 115/21       |                          |   |                  |                          |
| <input type="checkbox"/> HFA 230/21       |                          |   |                  |                          |
| 9) Symbicort.....                         | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A9A</u>  |                          |
| <input type="checkbox"/> 80/4.5           |                          |   | <u>RMU04A9B</u>  |                          |
| <input type="checkbox"/> 160/4.5          |                          |   |                  |                          |
| 10) Other, specify:.....                  | <input type="checkbox"/> | → |                  | <input type="checkbox"/> |
|   |                          |   | <u>RMU04A10A</u> |                          |
|   |                          |   | <u>RMU04A10B</u> |                          |



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5) Have you used inhaled bronchodilators in the past 3 months? .....  **RMU05**

Yes.....Y

No.....N → **Go to Item 6**

Don't know.....U → **Go to Item 6**

5a) Which bronchodilators have you used in the past 3 months?

	Yes	Puffs/day	No
1) albuterol (Proventil, Ventolin, ProAir) <b>RMU05A1</b> <input type="checkbox"/>	→	<b>RMU05A1A</b>	<input type="checkbox"/>
2) ipratropium bromide (Atrovent) ..... <b>RMU05A2</b> <input type="checkbox"/>	→	<b>RMU05A2A</b>	<input type="checkbox"/>
3) ipratropium bromide/albuterol sulfate (Combivent) <input type="checkbox"/>	→	<b>RMU05A3A</b>	<input type="checkbox"/> <b>RMU05A3</b>
4) terbutaline (Brethaire, Brethine, Bricanyl) ..... <input type="checkbox"/>	→	<b>RMU05A4A</b>	<input type="checkbox"/> <b>RMU05A4</b>
5) formoterol (Foradil)..... <b>RMU05A5</b> <input type="checkbox"/>	→	<b>RMU05A5A</b>	<input type="checkbox"/>
6) tiotropium (Spiriva) ..... <b>RMU05A6</b> <input type="checkbox"/>	→	<b>RMU05A6A</b>	<input type="checkbox"/>
7) salmeterol (Serevent Diskus)..... <b>RMU05A7</b> <input type="checkbox"/>	→	<b>RMU05A7A</b>	<input type="checkbox"/>
8) pirbuterol (Maxair)..... <b>RMU05A8</b> <input type="checkbox"/>	→	<b>RMU05A8A</b>	<input type="checkbox"/>
9) metaproterenol (Alupent, Metaprel)..... <b>RMU05A9</b> <input type="checkbox"/>	→	<b>RMU05A9A</b>	<input type="checkbox"/>
10) levalbuterol (Tomalate) ..... <b>RMU05A10</b> <input type="checkbox"/>	→	<b>RMU05A10A</b>	<input type="checkbox"/>
11) bitolterol (Tornalate)..... <b>RMU05A11</b> <input type="checkbox"/>	→	<b>RMU05A11A</b>	<input type="checkbox"/>
12) epinephrine (Primatene, Bronkaid) <b>RMU05A12</b> <input type="checkbox"/>	→	<b>RMU05A12A</b>	<input type="checkbox"/>
13) fluticasone/salmeterol (Advair Discus) ..... <input type="checkbox"/>	→	<b>RMU05A13A</b>	<input type="checkbox"/> <b>RMU05A13</b>
14) budesonide/formoterol (Symbicort) <b>RMU05A14</b> <input type="checkbox"/>	→	<b>RMU05A14A</b>	<input type="checkbox"/>
15) Other, specify..... <b>RMU05A15</b> <input type="checkbox"/>	→	<b>RMU05A15A</b>	<input type="checkbox"/>
<b>RMU05A15B</b>			

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6) Have you used nebulized bronchodilators in the past 3 months? .....  **RMU06**  
Yes.....Y  
No.....N → **Go to Item 7**  
Don't know.....U → **Go to Item 7**

6a) Which nebulized bronchodilators have you used in the past 3 months?

- |   | Yes                      | No                                      |
|---|--------------------------|---|
| 1) formoterol (Perforomist).....                    | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU06A1</b> |
| 2) arformoterol (Brovana) .....                     | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU06A2</b> |
| 3) albuterol and ipratropium bromide (DuoNeb) ..... | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU06A3</b> |
| 4) albuterol (Proventil, Ventolin, ProAir).....     | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU06A4</b> |
| 5) ipratropium bromide (Atrovent) .....             | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU06A5</b> |

7) Have you used a leukotriene antagonist (zafirlukast [Accolate], zileuton [Zyflo] or montelukast [Singulair]) in the past 3 months? .....  **RMU07**  
Yes.....Y  
No.....N  
Don't know.....U

8) Have you used any statin medications in the past 3 months? .....  **RMU08**  
Yes.....Y  
No.....N → **Go to Item 9**  
Don't know.....U → **Go to Item 9**

8a) Which statin medications have you used in the past 3 months?

- |  | Yes                      | No                                      |
|--|--------------------------|---|
| 1) Crestor (resuvastatin).....           | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A1</b> |
| 2) Lescol (fluvastatin) .....            | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A2</b> |
| 3) Lipitor (atorvastatin).....           | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A3</b> |
| 4) Mevacor (lovastatin) .....            | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A4</b> |
| 5) Pravachol (pravastatin).....          | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A5</b> |
| 6) Vytorin (ezetimibe, simvastatin)..... | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A6</b> |
| 7) Zocor (simvastatin) .....             | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A7</b> |
| 8) Other, specify .....                  | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU08A8</b> |
- RMU08A8B**
-

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9) Have you used any beta-blocker medications in the past 3 months? .....  **RMU09**  
Yes.....Y  
No.....N → **Go to Item 10**  
Don't know.....U → **Go to Item 10**

9a) Which beta-blocker medications have you used in the past 3 months?

- |   | Yes                      | No  |
|---|--------------------------|---|
| 1) Atenolol (tenormin, tenoretic).....  | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A1</b>   |
| 2) Metoprolol (lopressor, toprol).....  | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A2</b>   |
| 3) Carvedilol (coreg).....              | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A3</b>   |
| 4) Labetalol (trandate, normodyne)..... | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A4</b>   |
| 5) Propranolol (Inderal, Inderide)..... | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A5</b>   |
| 6) Sotalol (Betapace, Sorine).....      | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A6</b>   |
| 7) timolol (Blocardren, timolide).....  | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A7</b>   |
| 8) bisoprolol (zebeta, ziac).....       | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A8</b>   |
| 9) pindolol (visken).....               | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A9</b>   |
| 10) Other, specify.....                 | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU09A10</b>  |
|   |                          | <input type="checkbox"/> <b>RMU09A10B</b> |

10) Have you used any oral anti-oxidant supplements in the past 3 months? .....  **RMU10**  
Yes.....Y  
No.....N → **Go to Item 11**  
Don't know.....U → **Go to Item 11**

10a) Which antioxidant medications have you used in the past 3 months?

- |                                      | Yes                      | No                                       |
|--------------------------------------|--------------------------|--|
| 1) Vitamin C (ascorbic acid).....    | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A1</b>  |
| 2) Vitamin E (alpha-tocopherol)..... | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A2</b>  |
| 3) beta carotene.....                | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A3</b>  |
| 4) zinc.....                         | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A4</b>  |
| 5) copper.....                       | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A5</b>  |
| 6) fish oil.....                     | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A6</b>  |
| 7) omega 3.....                      | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A7</b>  |
| 8) Other, specify.....               | <input type="checkbox"/> | <input type="checkbox"/> <b>RMU10A8</b>  |
|                                      |                          | <input type="checkbox"/> <b>RMU10A8B</b> |

11) Are you currently using aspirin on a daily basis? .....  **RMU11**  
Yes.....Y  
No.....N

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12) Please list any other medications you have used in the past 3 months that are not listed above:

- 12a) RMU12A \_\_\_\_\_
- 12b) RMU12B \_\_\_\_\_
- 12c) RMU12C \_\_\_\_\_
- 12d) RMU12D \_\_\_\_\_
- 12e) RMU12E \_\_\_\_\_
- 12f) RMU12F \_\_\_\_\_
- 12g) RMU12G \_\_\_\_\_
- 12h) RMU12H \_\_\_\_\_
- 12i) RMU12I \_\_\_\_\_

13) Please list any other supplements you have used in the past 3 months that are not listed above:

- 13a) RMU13A \_\_\_\_\_
- 13b) RMU13B \_\_\_\_\_
- 13c) RMU13C \_\_\_\_\_
- 13d) RMU13D \_\_\_\_\_
- 13e) RMU13E \_\_\_\_\_
- 13f) RMU13F \_\_\_\_\_
- 13g) RMU13G \_\_\_\_\_
- 13h) RMU13H \_\_\_\_\_
- 13i) RMU13I \_\_\_\_\_



# REVIEW TRACKING FORM

ID NUMBER:									
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FORM CODE: **RTF**  
VERSION: **1.0** 01/20/16

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0a. Form Completion Date.... / **RTF0A** 0b. Staff Code .....  **RTF0B**

0c. Event ID:  **RTF0C** 0d. Event Date: / **RTF0D**

## PART A: Reviewer Assignment

1. Reviewer 1:  **RTF1**

2. Date Assigned: / **RTF2**

3. Review Complete: Yes  No  **RTF3**

4. Reviewer 2:  **RTF4**

5. Date assigned: / **RTF5**

6. Review Complete: Yes  No  **RTF6**

## PART B: Adjudication

7. Adjudication Required: Yes  No  **RTF7**

8. Reviewer 3:  **RTF8**

9. Date assigned: / **RTF9**

10. Adjudication Complete: Yes  No  **RTF10**

## PART C: Special Review and Event Classification

11. Special Review was completed: Yes  No  **RTF11**

12. Event Classification Complete: Yes  No  Pending  Not Required  **RTF12**



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FORM CODE: SDF  
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4) Was post-bronchodilator (ipratropium & albuterol) spirometry measured? .....  **SDF04**

Yes.....Y

No.....N → **Go to Item 7**

a) Time first puff of bronchodilator (ipratropium) administered:       AM/PM (circle one) **SDF04A** **SDF04A\_AMPM**

b) Time slow vital capacity procedure began:       AM/PM (circle one) **SDF04B** **SDF04B\_AMPM**

5) Post-bronchodilator spirometry values:

a) Inspiratory capacity.....  .   L-BTPS **SDF05A**

b) Expiratory slow vital capacity .....   .  L-BTPS **SDF05B**

c) FEV<sub>1</sub>.....  .   L-BTPS **SDF05C**

d) FVC.....  .   L-BTPS **SDF05D**

6) Did the post-bronchodilator spirometry (FEV<sub>1</sub> and FVC) meet the ATS-ERS requirements for acceptability and repeatability? (Y/N) .....  **SDF06**

7) Were there any complications during spirometry? (Y/N) .....  **SDF07**

a) If yes, please explain: **SDF07A** \_\_\_\_\_

8) Other comments: **SDF08** \_\_\_\_\_





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The following two questions ask you about your physical health and your daily activities.

3a) During the past four weeks, how much of the time have you accomplished less than you would like as a result of your physical health? [READ RESPONSE CHOICES] .....  SFH03A

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time ..... 3
- A little of the time ..... 4
- Or None of the time ..... 5

3b) During the past four weeks, how much of the time were you limited in the kind of work or other regular daily activities you do as a result of your physical health?

[READ RESPONSE CHOICES] .....  SFH03B

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time ..... 3
- A little of the time ..... 4
- Or None of the time ..... 5

The following two questions ask you about your emotions and your daily activities.

4a) During the past four weeks, how much of the time have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?

[READ RESPONSE CHOICES] .....  SFH04A

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time ..... 3
- A little of the time ..... 4
- Or None of the time ..... 5

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4b) During the past four weeks, how much of the time were you limited in the kind of work or other regular daily activities you do as a result of any emotional problems, such as feeling depressed or anxious? [READ RESPONSE CHOICES] .....  SFH04B

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time..... 3
- A little of the time ..... 4
- Or None of the time..... 5

5) During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

[READ RESPONSE CHOICES].....  SFH05

(Choose one number)

- Not at all ..... 1
- A little bit ..... 2
- Moderately ..... 3
- Quite a bit ..... 4
- Or Extremely ..... 5

The next questions are about how you feel and how things have been with you during the past 4 weeks.

As I read each statement, please give me the one answer that comes closest to the way you have been feeling; is it all of the time, most of the time, some of the time, a little of the time, or none of the time?

6a) How much of the time during the past four weeks...have you felt calm and peaceful? [READ

RESPONSE CHOICES ONLY IF NECESSARY] (Choose one number) .....  SFH06A

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time..... 3
- A little of the time ..... 4
- Or None of the time..... 5

6b) How much of the time during the past four weeks...did you have a lot of energy? [READ

RESPONSE CHOICES ONLY IF NECESSARY] (Choose one number) .....  SFH06B

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time..... 3
- A little of the time ..... 4
- Or None of the time..... 5

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6c) How much of the time during the past four weeks...have you felt downhearted and depressed?

[READ RESPONSE CHOICES ONLY IF NECESSARY] (Circle one number).....  SFH06C

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time..... 3
- A little of the time ..... 4
- Or None of the time..... 5

7) During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? [READ

RESPONSE CHOICES] (Choose one number) .....  SFH07

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time..... 3
- A little of the time ..... 4
- Or None of the time..... 5



# SF12v2 HEALTH SURVEY

ID NUMBER:	<b>BLINDID</b>				
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0a) Form Date .....   /   /     **SFH0A**    0b) Initials .....

**Instructions:** This form should be completed during the participant's visit. Please read the script exactly as written.

The first question is about your health now.

Please try to answer as accurately as you can.

- 1) In general, would you say your health is (Choose one number).....  **SFH01**
- Excellent ..... 1
  - Very good ..... 2
  - Good..... 3
  - Fair ..... 4
  - Poor ..... 5

Now I'm going to read a list of activities that you might do during a typical day.

As I read each item, please tell me if your health now limits you a lot, limits you a little, or does not limit you at all in these activities.

- 2a) ...moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf. Does your health now limit you a lot, limit you a little, or not limit you at all? [READ RESPONSE CHOICES].....  **SFH02A**  
 [IF RESPONDENT SAYS S/HE DOES NOT DO ACTIVITY, PROBE: Is that because of your health?]  
 (Choose one number)
- Yes, Limited a lot ..... 1
  - Yes, Limited a little ..... 2
  - or No, Not at all limited. .... 3

- 2b) ...climbing several flights of stairs. Does your health now limit you a lot, limit you a little, or not limit you at all? [READ RESPONSE CHOICES].....  **SFH02B**  
 [IF RESPONDENT SAYS S/HE DOES NOT DO ACTIVITY, PROBE: Is that because of your health?]  
 (Choose one number)
- Yes, Limited a lot ..... 1
  - Yes, Limited a little ..... 2
  - Or No, Not at all limited. .... 3

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The following two questions ask you about your physical health and your daily activities.

3a) During the past four weeks, how much of the time have you accomplished less than you would like as a result of your physical health? [READ RESPONSE CHOICES] .....  SFH03A

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- A good bit of the time ..... 3
- Some of the time ..... 4
- A little of the time ..... 5
- Or None of the time ..... 6

3b) During the past four weeks, how much of the time were you limited in the kind of work or other regular daily activities you do as a result of your physical health?

[READ RESPONSE CHOICES] .....  SFH03B

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- A good bit of the time ..... 3
- Some of the time ..... 4
- A little of the time ..... 5
- Or None of the time ..... 6

The following two questions ask you about your emotions and your daily activities.

4a) During the past four weeks, how much of the time have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?

[READ RESPONSE CHOICES] .....  SFH04A

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- A good bit of the time ..... 3
- Some of the time ..... 4
- A little of the time ..... 5
- Or None of the time ..... 6

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4b) During the past four weeks, how much of the time were you limited in the kind of work or other regular daily activities you do as a result of any emotional problems, such as feeling depressed or anxious? [READ RESPONSE CHOICES] .....  SFH04B

(Choose one number)

- All of the time ..... 1
- Most of the time ..... 2
- A good bit of the time ..... 3
- Some of the time ..... 4
- A little of the time ..... 5
- Or None of the time ..... 6

5) During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

[READ RESPONSE CHOICES] .....  SFH05

(Choose one number)

- Not at all ..... 1
- Slightly ..... 2
- Moderately ..... 3
- Quite a bit ..... 4
- Or Extremely ..... 5

The next questions are about how you feel and how things have been with you during the past 4 weeks.

As I read each statement, please give me the one answer that comes closest to the way you have been feeling; is it all of the time, most of the time, some of the time, a little of the time, or none of the time?

6a) How much of the time during the past four weeks...have you felt calm and peaceful? [READ RESPONSE CHOICES ONLY IF NECESSARY] (Choose one number) .....  SFH06A

- All of the time ..... 1
- Most of the time ..... 2
- A good bit of the time ..... 3
- Some of the time ..... 4
- A little of the time ..... 5
- Or None of the time ..... 6

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6b) **How much of the time during the past four weeks...did you have a lot of energy?** [READ

RESPONSE CHOICES ONLY IF NECESSARY] (Choose one number) .....  SFH06B

- All of the time ..... 1
- Most of the time ..... 2
- A good bit of the time ..... 3
- Some of the time ..... 4
- A little of the time ..... 5
- Or None of the time ..... 6

6c) **How much of the time during the past four weeks...have you felt downhearted and depressed?**

[READ RESPONSE CHOICES ONLY IF NECESSARY] (Circle one number) .....  SFH06C

- All of the time ..... 1
- Most of the time ..... 2
- A good bit of the time ..... 3
- Some of the time ..... 4
- A little of the time ..... 5
- Or None of the time ..... 6

7) **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?** [READ

RESPONSE CHOICES] (Choose one number) .....  SFH07

- All of the time ..... 1
- Most of the time ..... 2
- Some of the time ..... 3
- A little of the time ..... 4
- Or None of the time ..... 5





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6) How often do you have good days (with few respiratory problems)? .....  **SGR06**  
 No good days ..... A  
 A few good days ..... B  
 Most days are good ..... C  
 Every day is good ..... D

7) If you have a wheeze, is it worse when you get up in the morning? .....  **SGR07**  
 Yes ..... Y  
 No ..... N

**PART 2**

8) How would you describe your respiratory problems? .....  **SGR08**  
 Causes me a lot of problems or are  
 the most important physical problem I have ..... A  
 Causes me a few problems ..... B  
 Cause no problems ..... C

9) Questions about what activities usually make you feel breathless.  
 For each statement please tell me which applies to you these days.

	True	False
Washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09A</b>
Walking around the house	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09B</b>
Walking outside on the level ground	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09C</b>
Walking up a flight of stairs	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09D</b>
Walking up hills	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09E</b>

10) Some more questions about your cough and breathlessness.  
 For each statement please tell me which applies to you these days.

	True	False
Coughing hurts	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10A</b>
Coughing makes me tired	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10B</b>
I am short of breath when I talk	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10C</b>
I am short of breath when I bend over	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10D</b>
My cough or breathing disturbs my sleep	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10E</b>
I get exhausted easily	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10F</b>

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11) Questions about other effects that your chest trouble may have on you.  
For each statement please tell me which applies to you these days.

	True	False
My cough or breathing is embarrassing in public	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR11A</b>
My respiratory problems are a nuisance to my family, friends or neighbors	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR11B</b>
I get afraid or panic when I cannot catch my breath	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR11C</b>
I feel that I am not in control of my respiratory problems	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR11D</b>
I have become frail or an invalid because of my respiratory problems	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR11E</b>
Exercise is not safe for me	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR11F</b>
Everything seems too much of an effort	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR11G</b>

12) These are questions about how your activities might be affected by your respiratory problems.  
For each statement please tell me which applies to you because of your breathing.

	True	False
I take a long time to get washed or dressed	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12A</b>
I cannot take a bath or shower, or I take a long time to do it	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12B</b>
I walk slower than other people, or I stop to rest	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12C</b>
Jobs such as house chores take a long time, or I have to stop to rest	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12D</b>
If I walk up one flight of stairs, I have to go slowly or stop	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12E</b>
If I hurry or walk fast, I have to stop or slow down	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12F</b>
My breathing makes it difficult to do things such as walk up hills, carrying things up stairs, light gardening such as weeding, dance, bowl or play golf	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12G</b>
My breathing makes it difficult to do things such as carry heavy loads, dig the garden or shovel snow, jog or walk briskly (5 miles per hour), play tennis or swim	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR12H</b>

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13) We would like to know how your chest usually affects your daily life.  
For each statement please tell me which applies to you because of your breathing.

	True	False
I cannot play sports or do other physical activities	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR13A</b>
I cannot go out for entertainment or recreation	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR13B</b>
I cannot go out of the house to do the shopping	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR13C</b>
I cannot do household chores	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR13D</b>
I cannot move far from my bed or chair	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR13E</b>

14) How does your respiratory problems affect you? **SGR14**  
Please pick ONE:

- They do not stop me doing anything I would like to do
- They stop from me doing one or two things I would like to do
- They stop from me doing most of the things I would like to do
- They stop from me doing everything I would like to do



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- 6) How often do you have good days (with little chest trouble)? .....  **SGR06**
- No good days ..... A
  - A few good days ..... B
  - Most days are good..... C
  - Every day is good..... D

- 7) If you have a wheeze, is it worse in the morning? .....  **SGR07**
- Yes..... Y
  - No ..... N

**PART 2**

- 8) How would you describe you chest condition? .....  **SGR08**
- Causes me quite a lot of problems or is the most important problem I have..... A
  - Causes me a few problems..... B
  - Causes no problem ..... C

9) Questions about what activities usually make you feel breathless.  
For each statement please tell me which applies to you these days.

	True	False
Getting washed or dressed	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09A</b>
Walking around the home	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09B</b>
Walking outside on the level	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09C</b>
Walking up a flight of stairs	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09D</b>
Walking up hills	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR09E</b>

10) Some more questions about your cough and breathlessness.  
For each statement please tell me which applies to you these days.

	True	False
My cough hurts	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10A</b>
My cough makes me tired	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10B</b>
I am breathless when I talk	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10C</b>
I am breathless when I bend over	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10D</b>
My cough or breathing disturbs my sleep	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10E</b>
I get exhausted easily	<input type="checkbox"/>	<input type="checkbox"/> <b>SGR10F</b>

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11) Questions about other effects that your chest trouble may have on you.  
For each statement please tell me which applies to you these days.

	True	False
My cough or breathing is embarrassing in public	<input type="checkbox"/>	<input type="checkbox"/> SGR11A
My chest trouble is a nuisance to my family, friends or neighbors	<input type="checkbox"/>	<input type="checkbox"/> SGR11B
I get afraid or panic when I cannot get my breath	<input type="checkbox"/>	<input type="checkbox"/> SGR11C
I feel that I am not in control of my chest problem	<input type="checkbox"/>	<input type="checkbox"/> SGR11D
I have become frail or an invalid because of my chest	<input type="checkbox"/>	<input type="checkbox"/> SGR11E
Exercise is not safe for me	<input type="checkbox"/>	<input type="checkbox"/> SGR11F
Everything seems too much or an effort	<input type="checkbox"/>	<input type="checkbox"/> SGR11G

12) These are questions about how your activities might be affected by your breathing.  
For each statement please tell me which applies to you because of your breathing.

	True	False
I take a long time to get washed or dressed	<input type="checkbox"/>	<input type="checkbox"/> SGR12A
I cannot take a bath or shower, or I take a long time	<input type="checkbox"/>	<input type="checkbox"/> SGR12B
I walk slower than other people, or I stop for rests	<input type="checkbox"/>	<input type="checkbox"/> SGR12C
Jobs such as house work take a long time, or I have to stop for rests	<input type="checkbox"/>	<input type="checkbox"/> SGR12D
If I walk up one flight of stairs, I have to go slowly or stop	<input type="checkbox"/>	<input type="checkbox"/> SGR12E
If I hurry or walk fast, I have to stop or slow down	<input type="checkbox"/>	<input type="checkbox"/> SGR12F
My breathing makes it difficult to do things such as walk up hills, carrying things up stairs, light gardening such as weeding, dance, play bowls or play golf	<input type="checkbox"/>	<input type="checkbox"/> SGR12G
My breathing makes it difficult to do things such as carry heavy loads, dig the garden or shovel snow, jog or walk at 5 miles per hour, play tennis or swim	<input type="checkbox"/>	<input type="checkbox"/> SGR12H

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13) We would like to know how your chest usually affects your daily life.  
For each statement please tell me which applies to you because of your breathing.

	True	False
I cannot play sports or games	<input type="checkbox"/>	<input type="checkbox"/> SGR13A
I cannot go out for entertainment or recreation	<input type="checkbox"/>	<input type="checkbox"/> SGR13B
I cannot go out of the house to do the shopping	<input type="checkbox"/>	<input type="checkbox"/> SGR13C
I cannot do housework	<input type="checkbox"/>	<input type="checkbox"/> SGR13D
I cannot move far from my bed or chair	<input type="checkbox"/>	<input type="checkbox"/> SGR13E

14) How does your chest trouble effect you? SGR14  
Please pick ONE:

It does not stop me doing anything I would like to do	<input type="checkbox"/>
It stops me doing one or two things I would like to do	<input type="checkbox"/>
It stops me doing most of the things I would like to do	<input type="checkbox"/>
It stops me doing everything I would like to do	<input type="checkbox"/>





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- 5) Continuous oximetry recorded? (Y/N) .....  SMW05
- 6) Start time of 6-minute walk:   AM/PM (circle one) SMW06\_AMPM
- 7) Immediately following 6MW
- a) SpO2 .....    % SMW07A
- b) Pulse.....    min<sup>-1</sup> SMW07B
- c) Breathlessness.....   SMW07C
- d) Exertion.....   SMW07D
- 8a) Type of course used.....  SMW08A
- i) 30 meters x 2 lengths ..... 1
- ii) 100 feet x 2 lengths ..... 2
- iii) Other..... 3
- Specify\_  SMW08A1
- 8b) Number of full laps (2 lengths or legs):   SMW08B
- 8c) Distance walked final partial lap (in meters if 8a is meters, feet if 8a is in feet):    SMW08C
- 9) Stopped before 6 minutes? (Y/N)  SMW09
- Yes..... Y
- No ..... N → **Go to 10**
- a) Duration (minutes:seconds):   .   SMW09A1 SMW09A2
- 10) Give primary reason for stopping or not walking faster: .....
1. Desaturation to <80%  SMW09B1
2. Foot, knee, hip or other orthopedic pain  SMW09B2
3. Muscle fatigue or pain  SMW09B3
4. Breathlessness  SMW09B4
5. Adverse event  SMW09B5
- If yes to adverse event, select all that apply (this does not replace completing the Adverse Event Form):
- a. Angina.....  SMW09B5A
- b. Lightheadedness.....  SMW09B5B
- c. Intolerable dyspnea (required rescue inhaler).....  SMW09B5C
- d. Leg cramps .....  SMW09B5D
- e. Staggering.....  SMW09B5E

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- f. Diaphoresis ..... 

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**SMW09B5F**
- g. Pale or ashen appearance ..... 

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**SMW09B5G**
- h. Mental confusion or headache ..... 

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**SMW09B5H**
- i. Other ..... 

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**SMW09B5I**  
    please explain **SMW09B5ISP** \_\_\_\_\_



# SPUTUM PROCESSING WORKSHEET

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0a) Form Date .....   /   /     **SPW0A** 0b) Initials .....

0c) Date Collected .....   /   /      **SPW0C**

0d) Processing Started .....     **SPW0D** AM/PM (circle one)   **SPW0D\_AMP**

0e) Processing Ended .....     **SPW0E** AM/PM (circle one)   **SPW0E\_AMP**

**Instructions:** Complete this form while processing the sputum sample. Carefully record all data in the space provided.

1) Weight of Entire Sample .....    .   grams **SPW01**

### Color and Description of Sample:

#### 2) Salivary Contamination:

- Minimal **SPW02A**
- Mild **SPW02B**
- Moderate **SPW02C**
- Excessive **SPW02D**

#### 3) Consistency:

- Watery **SPW03A**
- Muroid **SPW03B**
- Purulent (puss) **SPW03C**

#### 4) Mucus "plugs":

- Numerous **SPW04A**
- Moderate number **SPW04B**
- Sparse **SPW04C**
- Large **SPW04D**
- Small **SPW04E**
- Dense/flocculent **SPW04F**
- Diffuse opacity **SPW04G**

#### 5) Color of plugs:

- Clear **SPW05A**
- White **SPW05B**
- Yellow/Tan **SPW05C**
- Brown **SPW05D**
- Green **SPW05E**

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**6) General Notes/Comments:** SPW06

6a) Sputum processing method ..... SPW06A

Method 1 (remove three aliquots then process with EDTA)..... 1

Method 2 (Immediately process with EDTA)..... 2 → Go to Item 10

**7) Processing Whole Sample using the Mucin Method (Complete only for method 1)**

Mucin Sample	Weight (g)
Weighing tray	a) <span style="border: 1px solid red; padding: 2px;">SPW07A</span>
Whole sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW07B</span>
Guanidine vol.	c) <span style="border: 1px solid red; padding: 2px;">SPW07C</span>

\*Sample size should be from 0.100-0.500g. If sample is 0.500g, 1mL of guanidine reduction buffer added. If less than 0.500g, 0.5mL guanidine reduction buffer added. Sample transferred from weighing tray to microcentrifuge tube. Sample should be stored in 4°C refrigerator.

**8) Processing Microbiology sample (Complete only for method 1)**

Micro Sample	Weight (g)
Microcentrifuge tube	a) <span style="border: 1px solid red; padding: 2px;">SPW08A</span>
Whole sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW08B</span>

\*Weigh an empty microcentrifuge tube. Zero the balance. Measure 0.250g of whole sputum sample. Record the weight of sputum and store in -80°C. Ship sample on dry ice.

**9) Processing Viscoelastic Sample (Complete only for method 1)**

Viscoelastic Sample	Weight (g)
Microcentrifuge tube	a) <span style="border: 1px solid red; padding: 2px;">SPW09A</span>
Whole Sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW09B</span>

\*Weigh an empty microcentrifuge tube. Zero the balance. Pipet 100uL of sample, drawing up whatever can be achieved. Transfer sample to microcentrifuge tube. Record the weight of sample and store in -80°C. Sample can be transferred to -20°C prior to delivery.

**10) Processing Whole Sample using EDTA:**

Weight of Centrifuge tube	a) <span style="border: 1px solid red; padding: 2px;">SPW10A</span>
Weight of Sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW10B</span>

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1% sputolysin volume	c) <b>SPW10C</b>
Volume EDTA added to make 0.1% sputolysin	d) <b>SPW10D</b>
Time of 15 minute tumble	e) <b>SPW10E</b>
Volume EDTA added after 15 minute tumble	f) <b>SPW10F</b>
Time of 5 minute tumble	g) <b>SPW10G</b>

\*Weigh a 50mL centrifuge tube. Zero the balance. Add remaining sample to centrifuge tube and record weight in grams. Add 0.1% Sputolysin in mLs equal to 4X selected sample weight in grams (For example, 2g of sample would need 8mL of 0.1% sputolysin). Place sample on tumble for 15 minutes. Dilute sample with EDTA. Use the same volume that was added above. Continue to tumble for an additional 5 minutes. After 5 minute tumble, sample is filtered through 53µm nylon mesh into new 50mL tube. Cells are spun down at 500Xg for 10 minutes.

### 11) Supernatants for Nucleotides and Cytokines

Supernatants	Number of aliquots	Volume stored
Nucleotides	a) <b>SPW11A</b>	b) <b>SPW11B</b>
Cytokines	c) <b>SPW11C</b>	d) <b>SPW11D</b>

\*If sample volume is greater than 8mL, obtain 4 1 mL aliquots for nucleotides, 4 1 mL aliquots for cytokines. When there is a limited volume, start by getting a nucleotide sample between 200-500uL, one cytokine sample at 200uL. If there is sample leftover after that, then continue alternating between nucleotide and cytokine aliquots (i.e. 200-500uL for nucleotides, 200uL for cytokines) until finished. Nucleotide and Cytokine samples are stored in -80°C freezer.

Volume of Hanks added	e) <b>SPW11E</b>
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### 12) Cell Counts

Cell Counts:	# Dead	#Live	Total
a) Square 1	1) <b>SPW12A1</b>	2) <b>SPW12A2</b>	3) <b>SPW12A3</b>
b) Square 2	1) <b>SPW12B1</b>	2) <b>SPW12B2</b>	3) <b>SPW12B3</b>
c) Square 3	1) <b>SPW12C1</b>	2) <b>SPW12C2</b>	3) <b>SPW12C3</b>
d) Square 4	1) <b>SPW12D1</b>	2) <b>SPW12D2</b>	3) <b>SPW12D3</b>
e) Totals:	1) <b>SPW12E1</b>	2) <b>SPW12E2</b>	3) <b>SPW12E3</b>

\*Count live (clear) and dead (blue) cells in each 4 corner grids. Count BEC's, but exclude RBC's and squamous.

TCC= (sum 4 grids/4 X 2 X 10 <sup>4</sup> X vol. sample	f) <b>SPW12F</b>
=TCC/weight of selected sample	g) <b>SPW12G</b>
Viability = (live cells/total cells) X 100%	h) <b>SPW12H</b>

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**13)Cytospins:**

	# slides stored
Hema 3 stained slides	a) <b>SPW13</b>

\*Slides are made using 60µL of cell suspension (1X10<sup>6</sup>/mL). Spin 6 min. at 450rpm (program 6 on cytospin). If possible, fix and stain 2 slides in Hema 3 stain (10 dips in each) and fix 2 slides in 95% ethanol. After air drying, stained slides are fixed with cyto seal and a cover slip. All slides stored at room temperature.

**14)Cells for RNA**

Trizol cell pellet	<b>SPW14</b>
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\*Cells are spun down at 500Xg for 5 minutes, HBSS's is discarded and 1mL Trizol is added. Add 10uL of GGD. The number of cells left in the Trizol pellet will be equal to the TCC (12f) minus the total number of cells used to make slides in 13.



# SPUTUM PROCESSING WORKSHEET

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0a) Form Date .....   /   /     **SPW0A**    0b) Initials.....

**Instructions:** Complete this form while processing the sputum sample. Carefully record all data in the space provided.

1) Weight of Entire Sample.....    .   grams **SPW01**

**Color and Description of Sample:**

**2) Salivary Contamination:**

- Minimal **SPW02A**
- Mild **SPW02B**
- Moderate **SPW02C**
- Excessive **SPW02D**

**3) Consistency:**

- Watery **SPW03A**
- Mucoid **SPW03B**
- Purulent (puss) **SPW03C**

**4) Mucus "plugs":**

- Numerous **SPW04A**
- Moderate number **SPW04B**
- Sparse **SPW04C**
- Large **SPW04D**
- Small **SPW04E**
- Dense/flocculent **SPW04F**
- Diffuse opacity **SPW04G**

**5) Color of plugs:**

- Clear **SPW05A**
- White **SPW05B**
- Yellow/Tan **SPW05C**
- Brown **SPW05D**
- Green **SPW05E**

**6) General Notes/Comments:** **SPW06**

ID NUMBER:									
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6a) Sputum processing method .....  **SPW06A**

Method 1 (remove three aliquots then process with EDTA)..... 1

Method 2 (Immediately process with EDTA)..... 2 → **Go to Item 10**

**7) Processing Whole Sample using the Mucin Method (Complete only for method 1)**

Mucin Sample	Weight (g)
Weighing tray	a) <b>SPW07A</b>
Whole sputum	b) <b>SPW07B</b>
Guanidine vol.	c) <b>SPW07C</b>

\*Sample size should be from 0.100-0.500g. If sample is 0.500g, 1mL of guanidine reduction buffer added. If less than 0.500g, 0.5mL guanidine reduction buffer added. Sample transferred from weighing tray to microcentrifuge tube. Sample should be stored in 4°C refrigerator.

**8) Processing Microbiology sample (Complete only for method 1)**

Micro Sample	Weight (g)
Microcentrifuge tube	a) <b>SPW08A</b>
Whole sputum	b) <b>SPW08B</b>

\*Weigh an empty microcentrifuge tube. Zero the balance. Measure 0.250g of whole sputum sample. Record the weight of sputum and store in -80°C. Ship sample on dry ice.

**9) Processing Viscoelastic Sample (Complete only for method 1)**

Viscoelastic Sample	Weight (g)
Microcentrifuge tube	a) <b>SPW09A</b>
Whole Sputum	b) <b>SPW09B</b>

\*Weigh an empty microcentrifuge tube. Zero the balance. Pipet 100uL of sample, drawing up whatever can be achieved. Transfer sample to microcentrifuge tube. Record the weight of sample and store in -80°C. Sample can be transferred to -20°C prior to delivery.

**10) Processing Whole Sample using EDTA:**

Weight of Centrifuge tube	a) <b>SPW10A</b>
Weight of Sputum	b) <b>SPW10B</b>
1% sputolysin volume	c) <b>SPW10C</b>



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Volume EDTA added to make 0.1% sputolysin	d) <b>SPW10D</b>
Time of 15 minute tumble	e) <b>SPW10E</b>
Volume EDTA added after 15 minute tumble	f) <b>SPW10F</b>
Time of 5 minute tumble	g) <b>SPW10G</b>

\*Weigh a 50mL centrifuge tube. Zero the balance. Add remaining sample to centrifuge tube and record weight in grams. Add 0.1% Sputolysin in mLs equal to 4X selected sample weight in grams (For example, 2g of sample would need 8mL of 0.1% sputolysin). Place sample on tumble for 15 minutes. Dilute sample with EDTA. Use the same volume that was added above. Continue to tumble for an additional 5 minutes. After 5 minute tumble, sample is filtered through 53µm nylon mesh into new 50mL tube. Cells are spun down at 500Xg for 10 minutes.

### 11)Supernatants for Nucleotides and Cytokines

Supernatants	Number of aliquots	Volume stored
Nucleotides	a) <b>SPW11A</b>	b) <b>SPW11B</b>
Cytokines	c) <b>SPW11C</b>	d) <b>SPW11D</b>

\*If sample volume is greater than 8mL, obtain 4 1 mL aliquots for nucleotides, 4 1 mL aliquots for cytokines. When there is a limited volume, start by getting a nucleotide sample between 200-500uL, one cytokine sample at 200uL. If there is sample leftover after that, then continue alternating between nucleotide and cytokine aliquots (i.e. 200-500uL for nucleotides, 200uL for cytokines) until finished. Nucleotide and Cytokine samples are stored in -80°C freezer.

Volume of Hanks added	e) <b>SPW11E</b>
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### 12)Cell Counts

Cell Counts:	# Dead	#Live	Total
a) Square 1	1) <b>SPW12A1</b>	2) <b>SPW12A2</b>	3) <b>SPW12A3</b>
b) Square 2	1) <b>SPW12B1</b>	2) <b>SPW12B2</b>	3) <b>SPW12B3</b>
c) Square 3	1) <b>SPW12C1</b>	2) <b>SPW12C2</b>	3) <b>SPW12C3</b>
d) Square 4	1) <b>SPW12D1</b>	2) <b>SPW12D2</b>	3) <b>SPW12D3</b>
e) Totals:	1) <b>SPW12E1</b>	2) <b>SPW12E2</b>	3) <b>SPW12E3</b>

\*Count live (clear) and dead (blue) cells in each 4 corner grids. Count BEC's, but exclude RBC's and squamous.

TCC= (sum 4 grids/4 X 2 X 10 <sup>4</sup> X vol. sample	f) <b>SPW12F</b>
=TCC/weight of selected sample	g) <b>SPW12G</b>
Viability = (live cells/total cells) X 100%	h) <b>SPW12H</b>

### 13)Cytospins:

	# slides stored
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Hema 3 stained slides	a) <b>SPW13</b>
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\*Slides are made using 60µL of cell suspension ( $1 \times 10^6$ /mL). Spin 6 min. at 450rpm (program 6 on cytospin). If possible, fix and stain 2 slides in Hema 3 stain (10 dips in each) and fix 2 slides in 95% ethanol. After air drying, stained slides are fixed with cytochrome seal and a cover slip. All slides stored at room temperature.

#### **14) Cells for RNA**

Trizol cell pellet	<b>SPW14</b>
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\*Cells are spun down at 500Xg for 5 minutes, HBSS's is discarded and 1mL Trizol is added. Add 10uL of GGD. The number of cells left in the Trizol pellet will be equal to the TCC (12f) minus the total number of cells used to make slides in 13.



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### 7) Processing Whole Sample using the Mucin Method

Mucin Sample	Weight (g)
Weighing tray	a) <span style="border: 1px solid red; padding: 2px;">SPW07A</span>
Whole sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW07B</span>
Guanidine vol.	c) <span style="border: 1px solid red; padding: 2px;">SPW07C</span>

\*Sample size should be from 0.100-0.500g. If sample is 0.500g, 1mL of guanidine reduction buffer added. If less than 0.500g, 0.5mL guanidine reduction buffer added. Sample transferred from weighing tray to microcentrifuge tube. Sample should be stored in 4°C refrigerator.

### 8) Processing Microbiology sample

Micro Sample	Weight (g)
Microcentrifuge tube	a) <span style="border: 1px solid red; padding: 2px;">SPW08A</span>
Whole sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW08B</span>

\*Weigh an empty microcentrifuge tube. Zero the balance. Measure 0.250g of whole sputum sample. Record the weight of sputum and store in -80°C. Ship sample on dry ice.

### 9) Processing Viscoelastic Sample

Viscoelastic Sample	Weight (g)
Microcentrifuge tube	a) <span style="border: 1px solid red; padding: 2px;">SPW09A</span>
Whole Sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW09B</span>

\*Weigh an empty microcentrifuge tube. Zero the balance. Pipet 100uL of sample, drawing up whatever can be achieved. Transfer sample to microcentrifuge tube. Record the weight of sample and store in -80°C. Sample can be transferred to -20°C prior to delivery.

### 10) Processing Whole Sample using EDTA:

Weight of Centrifuge tube	a) <span style="border: 1px solid red; padding: 2px;">SPW10A</span>
Weight of Sputum	b) <span style="border: 1px solid red; padding: 2px;">SPW10B</span>
1% sputolysin volume	c) <span style="border: 1px solid red; padding: 2px;">SPW10C</span>
Volume EDTA added to make 0.1% sputolysin	d) <span style="border: 1px solid red; padding: 2px;">SPW10D</span>
Time of 15 minute tumble	e) <span style="border: 1px solid red; padding: 2px;">SPW10E</span>
Volume EDTA added after 15 minute tumble	f) <span style="border: 1px solid red; padding: 2px;">SPW10F</span>

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Time of 5 minute tumble	g) <b>SPW10G</b>
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\*Weigh a 50mL centrifuge tube. Zero the balance. Add remaining sample to centrifuge tube and record weight in grams. Add 0.1% Sputolysin in mLs equal to 4X selected sample weight in grams (For example, 2g of sample would need 8mL of 0.1% sputolysin). Place sample on tumble for 15 minutes. Dilute sample with EDTA. Use the same volume that was added above. Continue to tumble for an additional 5 minutes. After 5 minute tumble, sample is filtered through 53µm nylon mesh into new 50mL tube. Cells are spun down at 500Xg for 10 minutes.

### 11)Supernatants for Nucleotides and Cytokines

Supernatants	Number of aliquots	Volume stored
Nucleotides	a) <b>SPW11A</b>	b) <b>SPW11B</b>
Cytokines	c) <b>SPW11C</b>	d) <b>SPW11D</b>

\*If sample volume is greater than 8mL, obtain 4 1 mL aliquots for nucleotides, 4 1 mL aliquots for cytokines. When there is a limited volume, start by getting a nucleotide sample between 200-500uL, one cytokine sample at 200uL. If there is sample leftover after that, then continue alternating between nucleotide and cytokine aliquots (i.e. 200-500uL for nucleotides, 200uL for cytokines) until finished. Nucleotide and Cytokine samples are stored in -80°C freezer.

Volume of Hanks added	e) <b>SPW11E</b>
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### 12)Cell Counts

Cell Counts:	# Dead	#Live	Total
a) Square 1	1) <b>SPW12A1</b>	2) <b>SPW12A2</b>	3) <b>SPW12A3</b>
b) Square 2	1) <b>SPW12B1</b>	2) <b>SPW12B2</b>	3) <b>SPW12B3</b>
c) Square 3	1) <b>SPW12C1</b>	2) <b>SPW12C2</b>	3) <b>SPW12C3</b>
d) Square 4	1) <b>SPW12D1</b>	2) <b>SPW12D2</b>	3) <b>SPW12D3</b>
e) Totals:	1) <b>SPW12E1</b>	2) <b>SPW12E2</b>	3) <b>SPW12E3</b>

\*Count live (clear) and dead (blue) cells in each 4 corner grids. Count BEC's, but exclude RBC's and squamous.

TCC= (sum 4 grids/4 X 2 X 10 <sup>4</sup> X vol. sample	f) <b>SPW12F</b>
=TCC/weight of selected sample	g) <b>SPW12G</b>
Viability = (live cells/total cells) X 100%	h) <b>SPW12H</b>

### 13)Cytospins:

	# slides stored
Hema 3 stained slides	a) <b>SPW13</b>

\*Slides are made using 60µL of cell suspension (1X10<sup>6</sup>/mL). Spin 6 min. at 450rpm (program 6 on cytospin). If possible, fix and stain 2 slides in Hema 3 stain (10 dips in each) and fix 2 slides in 95% ethanol. After air drying, stained slides are fixed with cyto seal and a cover slip. All slides stored at room temperature.

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#### 14) Cells for RNA

Trizol cell pellet	SPW14
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\*Cells are spun down at 500Xg for 5 minutes, HBSS's is discarded and 1mL Trizol is added. Add 10uL of GGD. The number of cells left in the Trizol pellet will be equal to the TCC (12f) minus the total number of cells used to make slides in 13.



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7. Is there a history of previous TIA?  Yes  No/NR (*Skip to 8*) **STR7**

a. Date of most recent TIA: (mm/dd/yyyy)   /   /     **STR7A**

8. History of myocardial infarction prior to this event?  Yes  No/NR **STR8**

9. Does the patient have a history of diabetes?  Yes  No/NR **STR9**

10. Are any of the following recent conditions documented as having been present within four weeks prior to onset or during this hospitalization?

	<u>Yes</u>	<u>No/NR</u>	
a. myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10A</b>
b. intracardiac thrombus or intracardiac tumor	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10B</b>
c. atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10C</b>
d. rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10D</b>
e. subacute bacterial endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10E</b>
f. systemic embolus	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10F</b>
g. hypercoagulable state	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10G</b>
h. hemorrhagic abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10H</b>
i. brain tumor	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10I</b>
j. major head trauma	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10J</b>
k. seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10K</b>
l. migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR10L</b>

### C. SIGNS AND SYMPTOMS

11. Were new neurological signs/symptoms present upon admission?  Yes  No/NR (*Skip to 12*) **STR11**

a. Length of time between onset of new neurological signs/symptoms and presentation:  **STR11A**  
1 = < 10 min, 2 = 10 - 59 min, 3 = 60 min.- 24 hrs, 4 = 24 hrs+, 5 = unknown



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12. Were any of the following present at onset prior to admission or during this hospitalization?

	<u>Yes</u>	<u>No/NR</u>	
a. Headache	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12A</b>
b. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12B</b>
c. Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12C</b>
d. Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12D</b>
e. Altered level of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12E</b>
f. Aphasia	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12F</b>
g. Anesthesia, dysesthesia or paresthesias of the face	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12G</b>
h. Anesthesia, dysesthesia or paresthesias of the extremities	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12H</b>
i. Visual field disturbance, diplopia	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12I</b>
j. Gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12J</b>
k. Cranial nerve III palsy	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12K</b>
l. Meningeal signs (ie: Brudinski's sign, Kernig's sign)	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR12L</b>

13. Did new neurological symptoms develop during this hospitalization?  Yes  No/NR (*Skip to 14*) **STR13**

a. If yes, did the event occur in the setting of a procedure?  Yes  No/NR (*Skip to 14*) **STR13A**

b. If yes, what procedure?

	<u>Yes</u>	<u>No/NR</u>	
1. Angiogram	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR13B1</b>
2. Cardiac surgery	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR13B2</b>
3. Carotid endarterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR13B3</b>
4. Other	<input type="checkbox"/>	<input type="checkbox"/>	<b>STR13B4</b>
i. Specify _____			<b>STR13B4A</b>

**D. DIAGNOSTIC TESTS**

14. Admission Blood pressure / mmHg **STR14**

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15. Was cerebrovascular imaging performed?  Yes  No/NR (Skip to 19) **STR15**

16. Was cerebrovascular angiography performed?  Yes  No/NR (Skip to 17) **STR16**

a. Angiography Diagnosis  **STR16A**  
1 = normal, 2 = ruptured aneurysm, 3 = Occlusion or Stenosis, 4 = Dissection, 5 = Venous Occlusion, 6 = Arteriovenous Malformation, 7 = Other

17. Was a CT scan of the head performed during this hospitalization?  Yes  No/NR (Skip to 18) **STR17**

a. CT Diagnosis  **STR17A**  
1 = normal, 2 = normal, but done within 48 hrs of symptom onset, 3 = subarachnoid hemorrhage, 4 = intracerebral hematoma, 5 = ischemic infarction, with no evidence of hemorrhage, 6 = hemorrhagic infarction

18. Was magnetic resonance imaging (MRI) of the head performed?  Yes  No/NR (Skip to 19) **STR18**

a. MRI Diagnosis  **STR18A**  
1 = normal, 2 = normal, but done within 48 hrs of symptom onset, 3 = subarachnoid hemorrhage, 4 = intracerebral hematoma, 5 = ischemic infarction, with no evidence of hemorrhage, 6 = hemorrhagic infarction

19. Was carotid magnetic resonance angiography (MRA) performed?  Yes  No/NR (Skip to 20) **STR19**

a. If Yes, what is the greatest degree of carotid stenosis demonstrated: **STR19A**

- 1. 0 – 49%
- 2. 50 – 69%
- 3. 70 – 99%
- 4. 100% (occlusion)

20. Was an echocardiography study performed?  Yes  No/NR (Skip to 21) **STR20**

a. If Yes, were the following present:

- 1. intracardiac thrombus  Yes  No **STR20A1**
- 2. valvular heart disease  Yes  No **STR20A2**

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- 3. dilated ventricle or poor ventricular function  Yes  No STR20A3
- 4. aortic arch atheroma  Yes  No STR20A4
- 5. atrioseptal aneurysm  Yes  No STR20A5
- 6. patent foramen ovale (PFO)  Yes  No STR20A6
- 7. valve vegetations  Yes  No STR20A7
- 8. artificial valve  Yes  No STR20A8

**E. TREATMENT**

21. Did the patient receive thrombolytic treatment for stroke?  Yes  No/NR STR21

**F. DISCHARGE**

22. Was the patient alive at discharge?  Yes  No/NR (*End form*) STR22

23. At the time of discharge, did the patient have deficits in completing everyday activities compared to status prior to event? STR23  Yes  No/NR

24. Where was the patient discharged to:  STR24

*1 = home, 2 = rehabilitation unit or facility, 3 = nursing home or other long term care facility*





# SPIROMICS VENOUS THROMBOEMBOLIC DISEASE ABSTRACTION FORM (VTD)

ID NUMBER:	<input type="text" value="SUBJID"/>	FORM CODE: VTD VERSION A 2/12/2015	Visit Number	<input type="text" value="VISIT"/>	SEQ #	<input type="text"/>	<input type="text"/>
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0a. Completion Date: / /        0b. Staff ID:

Month/Day/Year

0c. Event ID:        0d. Event Date: / /

Instructions: *Answers are derived from the medical records received. Do not complete this form until all records are received or classified as unobtainable as indicated on the Medical Record Shipping Form.*

## A. GENERAL INFORMATION

1. Was the event (*choose one*):

1= In hospital only      2= Emergency Dept. visit only (ED)      3= Both ED and in hospital

2. Date of admission: (mm/dd/yyyy)      / /

3. Date of discharge: (mm/dd/yyyy)      / /

4. What was the primary admitting diagnosis code?      .

5. What was the primary discharge diagnosis code?      .

## B. DEEP VEIN THROMBOSIS (DVT)

6. Was DVT confirmed? Yes  No  [*skip to 10*]

7. Diagnosis: (*Mark the one that applies best*)

a.  Deep vein thrombosis of lower extremities **not resulting from a procedure** within 60 days

b.  Deep vein thrombosis of lower extremities **during or following a procedure** within 60 days

8. Diagnosis of deep vein thrombosis is based on: (*Mark all that apply*)

a.  Hospital discharge summary with a diagnosis of deep vein thrombosis

b.  Positive findings on a venogram

c.  Positive findings using impedance plethysmography

d.  Positive findings on Doppler duplex, ultrasound, sonogram or other non-invasive test

e.  Positive findings on isotope scan

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9. Diagnosis of deep vein thrombosis reporting source (*Mark the one category that applies best*) **VTD9**

- a.  Hospital inpatient
- b.  Hospital outpatient facility or clinic
- c.  Radiology or imaging facility
- d.  Physician's office / private medical practitioner
- e.  Nursing/convalescent home/hospice
- f.  Autopsy only
- g.  Death Certificate only
- h.  Other, specify \_\_\_\_\_

**VTD9A**

10. Was a work-up for pulmonary embolism performed? Yes  No  (*End Form*) Unknown  (*End Form*)

**VTD10**

### C. PULMONARY EMBOLISM (PE)

11. Diagnosis: (*Mark the one that applies best*) **VTD11**

- a.  Pulmonary embolism **not resulting from a procedure** within 60 days
- b.  Pulmonary embolism **during or following a procedure** within 60 days
- c.  No Pulmonary embolism diagnosed or diagnosis is not recorded

12. Diagnosis of pulmonary embolism is based on: (*Mark all that apply*)

- a.  Hospital discharge summary with a diagnosis of pulmonary embolism **VTD12A**
- b.  High probability on ventilation-perfusion lung scan **VTD12B**
- c.  Positive findings on pulmonary angiogram or spiral CT **VTD12C**
- d.  Diagnosis of deep vein thrombosis (DVT) based on at least one DVT criteria on Q7 plus signs and symptoms suggestive of PE (i.e. acute chest pain, dyspnea, tachypnea, hypoxemia, tachycardia, or chest X-ray findings suggestive of PE) **VTD12D**
- e.  Other, including autopsy **VTD12E**

13. Does patient have a history of: (*Mark all that apply*)

- a.  Factor V Leiden deficiency **VTD13A**
- b.  Polycythemia **VTD13B**
- c.  Cancer **VTD13C**
- d.  Smoking **VTD13D**
- e.  Obesity **VTD13E**
- f.  Recent estrogen or birth control pill use **VTD13F**