SPIROMICS
SubPopulations and InteRmediate Outcome Measures In COPD Study

FOLLOW-UP MEDICATION USE

ID NUMBER:									

FORM CODE: **MEF**
VERSION: **1.0 08/27/2024**

Event: _____

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

Instructions: *This form should be completed during the participant's clinic visit. Initially, list all non-study medications that the participant is currently taking with regularity. Do NOT list medications that are taken "as needed" (PRN), unless they are taken at least once per week.*

Notes:

- *All questions should be answered thinking back to the last in-person clinic visit as the last contact so for most that will be Visit 5 in SPIROMICS and Visit 2 in SOURCE.*

1) Are you regularly using any medication(s)?

☐ No$_0$ → **Go to 15**

☐ Yes$_1$

1a) Total number of medications: ☐☐

NOTE: Pull the previous list of medications recorded (i.e., previously entered MED or MEF) during the participant's last in-person visit and review with the participant. Enter all previously recorded medication(s), if applicable, and any new medication(s) the participant is taking with regularity.

MEDICATION RECORD

Begin entering the ***Coded Medication Name*** *into* ***item (a)*** *and select the matching medication name (and dosage, if known). If the medication name is not found in the coding dictionary, enter the* ***Uncoded Medication Name*** *into* ***item (b)****. Enter the dosage* ***Strength*** *and* ***Units*** *in* ***item (c)*** *and* ***item (d)****, respectively, for all uncoded medications.*

2)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
3)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**

4)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
5)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
6)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
7)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
8)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
9)	**(a) Coded Medication Name**		

	(b) Uncoded Medication Name	(c) Strength	(d) Units
10)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
11)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
12)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
13)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**

14) Are any of the medications you take for: *(If Yes, verify that the **Medication Name** is on the medication record.)*

	No$_0$	Yes$_1$	Don't know$_2$
14a) Asthma	☐	☐	☐
14b) Chronic bronchitis or emphysema	☐	☐	☐
14c) High blood sugar or diabetes	☐	☐	☐
14d) High blood pressure or hypertension	☐	☐	☐

14e) High blood cholesterol	☐	☐	☐
14f) Chest pain or angina	☐	☐	☐
14g) Abnormal heart rhythm	☐	☐	☐
14h) Heart failure	☐	☐	☐
14i) Blood thinning	☐	☐	☐
14j) Stroke	☐	☐	☐
14k) Mini-stroke or TIA	☐	☐	☐
14l) Leg pain while walking or claudication	☐	☐	☐
14m) Other	☐	☐	☐

14m1) Please specify other: _____

15) Are you currently using supplemental oxygen (prescribed by your doctor) at home?

☐ No$_0$ → **Go to 16**
☐ Yes$_1$

15a) Approximately how many hours in a 24-hour period do you use oxygen? ☐☐ hours

15b) If you are using nighttime supplemental oxygen, do you use oxygen only at night?

☐ No$_0$
☐ Yes$_1$

16) Are you currently using or have you used nicotine replacement therapy (gum, patch, lozenge, or spray)?

☐ No, have never used$_0$
☐ Yes, currently using$_1$
☐ Yes, have used in the past, but not currently using$_2$

17) Are you currently using or have you used a prescription medication for tobacco cessation?

☐ No, have never used$_0$
☐ Yes, have used in the past, but not currently using$_1$
☐ Yes, currently using Chantix (varenicline)$_2$
☐ Yes, currently using Zyban (bupropion)$_3$

18) Are you currently using any oral antioxidant supplements (listed below)?

☐ No$_0$ → **Go to 19**
☐ Yes$_1$

If Yes, please indicate which supplement(s) you use regularly? *(check all that apply)*

18a) ☐ Vitamin A (beta carotene)
18b) ☐ Vitamin C (ascorbic acid)
18c) ☐ Vitamin D (cholecalciferol)
18d) ☐ Vitamin E (alpha-tocopherol)
18e) ☐ Zinc
18f) ☐ Copper
18g) ☐ Fish oil
18h) ☐ Omega 3
18i) ☐ Other

18i1) Please specify other: _____

19) Are you currently using or have you used any other medications (prescribed or over the counter) or supplements regularly that are not listed above?

☐ No$_0$ → **Go to End**
☐ Yes$_1$

If Yes, please list any other medications (prescribed or over the counter) or supplements not listed above:

19a) _____
19b) _____
19c) _____
19d) _____
19e) _____

END OF FORM