MEDICAL HISTORY FORM FOR FOLLOW-UP

ID NUMBER:									FORM CODE: **MHF** VERSION: **1.0** 9/21/11	Visit Number			SEQ #			

0a) Form Date ..... ☐☐/☐☐/☐☐☐☐ 0b) Staff Code .... ☐☐☐

Instructions: *Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes.*

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) Did you get an influenza vaccination (flu shot) in the last 12 months?
- ☐ Yes
- ☐ No

2) When was your most recent pneumonia vaccination? (Pneumovax)
- ☐ Never had
- ☐ Within past 5 years
- ☐ More than 5 years ago

3) Have you been diagnosed with alpha-1 anti-trypsin deficiency?
- ☐ Yes
- ☐ No
- ☐ Don't know

Have you ever seen a physician or other medical provider for any of the following kinds of problems in the last 12 months?

		Yes	No	Explain
4)	Eyes, ears, nose, throat			
a)	Vision problems	☐	☐	_____
b)	Hearing problems	☐	☐	_____
c)	Dizziness	☐	☐	_____
d)	Ears ringing	☐	☐	_____
e)	Sinusitis/rhinitis	☐	☐	_____
f)	Other	☐	☐	_____

		Yes	No	Explain
5)	Cardiovascular			
a)	High blood pressure	☐	☐	_____
b)	Coronary artery disease	☐	☐	_____
c)	Angina (chest pain)	☐	☐	_____
d)	Heart attack	☐	☐	_____
e)	Murmur	☐	☐	_____

f)	Palpitations, irregular heartbeat	☐	☐	_____
g)	Valve disease	☐	☐	_____
h)	Congestive heart failure	☐	☐	_____
i)	Blood clots	☐	☐	_____
j)	Poor circulation (claudication)	☐	☐	_____
k)	Other	☐	☐	_____

6) Gastrointestinal		Yes	No	Explain
a)	Esophageal condition or disease	☐	☐	_____
b)	Ulcers	☐	☐	_____
c)	Hepatitis or jaundice	☐	☐	_____
d)	Crohn's disease or colitis	☐	☐	_____
e)	Gallstones	☐	☐	_____
f)	Cirrhosis	☐	☐	_____
g)	GERD (heart burn)	☐	☐	_____
h)	Hiatal hernia	☐	☐	_____
i)	Other	☐	☐	_____

7) Pulmonary/vascular		Yes	No	Explain
a)	Intubation or respirator	☐	☐	_____
b)	Pneumothorax (collapsed lung)	☐	☐	_____
c)	Tuberculosis	☐	☐	_____
d)	Pulmonary fibrosis	☐	☐	_____
e)	Lung nodules	☐	☐	_____
f)	Pulmonary embolism	☐	☐	_____
g)	Other	☐	☐	_____

8) Oncology/hematology		Yes	No	Explain
a)	Cancer (except basal cell skin cancer)	☐	☐	_____
b)	Anemia	☐	☐	_____
c)	Other	☐	☐	_____

9) Genitourinary and reproductive		Yes	No	Explain
a)	Menstrual symptoms (women)	☐	☐	_____
b)	Enlarged prostate or BPH (men)	☐	☐	_____

c)	Bladder or kidney problems/ kidney stones	☐	☐	_____
d)	Other	☐	☐	_____

10) Endocrine		Yes	No	Explain
a)	Diabetes	☐	☐	_____
b)	Thyroid	☐	☐	_____
c)	Other	☐	☐	_____

11) Neurology		Yes	No	Explain
a)	Stroke	☐	☐	_____
b)	Headaches	☐	☐	_____
c)	Seizure	☐	☐	_____
d)	Other	☐	☐	_____

12) Muscular/skeletal		Yes	No	Explain
a)	Rheumatoid arthritis	☐	☐	_____
b)	Gout	☐	☐	_____
c)	Osteoporosis	☐	☐	_____
d)	Fractures	☐	☐	_____
e)	Joint pain	☐	☐	_____
f)	Osteoarthritis	☐	☐	_____
g)	Other	☐	☐	_____

13) Dermatology		Yes	No	Explain
a)	Rashes/hives/eczema	☐	☐	_____
b)	Psoriasis	☐	☐	_____
c)	Shingles	☐	☐	_____
d)	Other	☐	☐	_____

14) Infectious disease		Yes	No	Explain
a)	Atypical mycobacteria (MAC, MAI)	☐	☐	_____
b)	Fungal disease	☐	☐	_____
c)	Other	☐	☐	_____

15) Psychiatric		Yes	No	Explain
a)	Anxiety	☐	☐	_____
b)	Depression	☐	☐	_____
c)	Other	☐	☐	_____

16) Other significant problems not reported in questions 2-18 Yes ☐ No ☐

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

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) ..... ☐

18) A urinary tract infection? (Y/N) ..... ☐

19) Seasonal allergies? (Y/N)..... ☐

20) A sinus infection or sinusitis? (Y/N) ..... ☐

21) A tooth infection? (Y/N) ..... ☐

22) A flare up of gout? (Y/N)..... ☐

23) A flare up of arthritis? (Y/N)..... ☐

24) Other? (Y/N)..... ☐

25) Please explain:_____

26) Are you allergic to any medications, latex, food, or substances? (Y/N)..... ☐

If **YES**:

List substance:	Reaction
a)	
b)	
c)	
d)	
e)	

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)*

- 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)*

- 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 ☐
- Wine ☐
- Drinks containing liquor ☐

30) How often do you have eight or more drinks on one occasion?

- 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?

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

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

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?

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? ..... ☐

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

36) Did you ever use oral contraceptive medications? ..... ☐

Yes ..... Y
No ..... N → **Go to 38**

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

38) Did you ever use hormone replacement therapy? ..... ☐

Yes ..... Y
No ..... N → **Go to 40**

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

40) In the last 12-months have you been pregnant? ..... ☐☐

41) In the last 12-months did you ever breastfeed? ..... ☐

Yes ..... Y
No ..... N → **Go to 43**

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

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

Yes ..... Y
No ..... N → **Go to 46**

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

One ..... O
Both ..... B

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

46) Were you born premature? ..... ☐

Yes ..... Y
No ..... N → **Go to 47**
Don't Know ..... D → **Go to 47**

46a) If yes, how many weeks were you premature? ..... ☐☐ weeks

47) What was your birth weight? ..... ☐☐ pounds ☐☐ ounces

48) Did you ever have breathing problems during the first two years of life? ..... ☐

Yes ..... Y
No ..... N → **Go to 49**
Don't Know ..... D → **Go to 49**

48a) If yes, were you ever hospitalized for these problems? ..... ☐

Yes ..... Y
No ..... N
Don't Know ..... D

49) Were you ever hospitalized for pneumonia before 18 years of age? ..... ☐

Yes ..... Y
No ..... N
Don't Know ..... D