SPIROMICS
SubPopulations and InteRmediate Outcome Measures In COPD Study

FOLLOW-UP MEDICAL HISTORY

ID NUMBER:									

FORM CODE: **MHF**
VERSION: **1.0 09/03/2024**

Event: _____

0a) Date of Collection: ☐☐ / ☐☐ / ☐☐☐☐

0b) Staff Code: ☐☐☐

Instructions: *This form should be completed during the participant's clinic visit. All questions should be answered thinking back to the last in-person visit as the last contact so for most participant's that will be Visit 5 in SPIROMICS or Visit 3 in SOURCE.*

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

1) Did you get an influenza vaccination (flu shot) since your last in-person clinic visit?

- ☐ No$_0$
- ☐ Yes$_1$

1a) Did you get a respiratory syncytial virus (RSV) vaccination since your last in-person clinic visit?

- ☐ No$_0$ → **Go to 1b**
- ☐ Yes$_1$
- ☐ Don't know$_2$ → **Go to 1b**

1a1) If Yes, which vaccination did you receive?

- ☐ ABRYSVO$_1$
- ☐ Arexvy$_2$
- ☐ mRESVIA$_3$

1b) Did you get a COVID-19 vaccination or booster since your last in-person clinic visit?

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

2) Did you get a pneumonia vaccination since your last in-person clinic visit?

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

National Center for Health Statistics. (2024). 2024 National Health Interview Survey (NHIS) Questionnaire version 7. MHF items 34-36 retrieved from: https://www.cdc.gov/nchs/nhis/2024nhis.htm.

2a) If Yes, which vaccination did you receive? *(check all that apply)*

- 2a1) ☐ Pneumovax (PPSV-23)
- 2a2) ☐ Prevnar13 (PCV-13)
- 2a3) ☐ Prevnar20 (PCV-20)
- 2a4) ☐ Vaxneuvance (PCV-15)
- 2a5) ☐ Don't know
- 2a6) ☐ Other
  - 2a6a) If Other, please specify _____

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

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

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

4) Eyes, ears, nose, throat	No$_0$	Yes$_1$	If Yes, please explain:
4a) Vision problems	☐	☐	4a1) _____
4b) Hearing problems	☐	☐	4b1) _____
4c) Dizziness	☐	☐	4c1) _____
4d) Ears ringing	☐	☐	4d1) _____
4e) Sinusitis/rhinitis	☐	☐	4e1) _____
4f) Other	☐	☐	4f1) _____

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

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5m) Heart procedure for blockage (stent or balloon)	☐	☐	5l1) _____
5n) Heart procedure for pacemaker or abnormal heart rhythm	☐	☐	5n1) _____
5k5o) Other	☐	☐	5k15o1) _____

6) Gastrointestinal	No0	Yes1	If Yes, please explain:
6a) Esophageal condition or disease	☐	☐	6a1) _____
6b) Ulcers	☐	☐	6b1) _____
6c) Hepatitis or jaundice	☐	☐	6c1) _____
6d) Crohn's disease or colitis	☐	☐	6d1) _____
6e) Gallstones	☐	☐	6e1) _____
6f) Cirrhosis	☐	☐	6f1) _____
6g) GERD (heart burn)	☐	☐	6g1) _____
6h) Hiatal hernia	☐	☐	6h1) _____
6i) Other	☐	☐	6i1) _____

7) Pulmonary/vascular	No0	Yes1	If Yes, please explain:
7a) Intubation or respirator	☐	☐	7a1) _____
7b) Pneumothorax (collapsed lung)	☐	☐	7b1) _____
7c) Tuberculosis	☐	☐	7c1) _____
7d) Pulmonary fibrosis	☐	☐	7d1) _____
7e) Lung nodules	☐	☐	7e1) _____
7f) Pulmonary embolism or blood clot in lung	☐	☐	7f1) _____
7h7g) Wedge resection (surgery to remove part or all of the lung)	☐	☐	7h17g1) _____
7h) Biopsy of lung with surgery or procedure	☐	☐	7h1) _____
7g7i) Other	☐	☐	7g17i1) _____

8) Oncology/hematology	No0	Yes1	If Yes, please explain:
8a) Cancer (except basal cell skin cancer)	☐	☐	8a1) _____
8b) Anemia	☐	☐	8b1) _____
8c) Other	☐	☐	8c1) _____

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

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

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

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

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

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

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

16) Other significant problems not reported in questions 4 -15	No$_0$	Yes$_1$	If Yes, please list:
	☐	☐	16a) _____
			16b) _____
			16c) _____
			16d) _____
			16e) _____

16f) Have you ever had lung volume reduction surgery before?

☐ No$_0$→ **Go to 16g**

☐ Yes$_1$

16f1) If Yes, when? ☐☐ / ☐☐☐☐

16f2) Which lung?

☐ Left$_1$

☐ Right$_2$

☐ Both$_3$

16g) Have you ever had a bronchoscopic lung volume reduction procedure before, such as placement of valves?

☐ No$_0$→ **Go to 16h**

☐ Yes$_1$

16g1) If Yes, when? ☐☐ / ☐☐☐☐

16g2) Which lung?

☐ Left$_1$

☐ Right$_2$

☐ Both$_3$

16h) Have you ever had a lung transplant before?

☐ No$_0$→ **Go to 17**

☐ Yes$_1$

16h1) If Yes, when? ☐☐ / ☐☐☐☐

16h2) Which lung?

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- ☐ Left$_1$
- ☐ Right$_2$
- ☐ Both$_3$

Now I am going to ask you some questions about your possible use of alcoholic beverages or drugs, not including cannabis (marijuana, hashish), since your last in-person clinic visit. By alcoholic beverages, I mean beer, wine, vodka, etc. Please remember that all information that you give us is confidential, and only certified personnel will have access to this information.

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

- ☐ Never$_0$ → **Go to 25**
- ☐ Monthly or less$_1$
- ☐ 2 to 4 times per month$_2$
- ☐ 2 to 3 times per week$_3$
- ☐ 4 or more times per week$_4$

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

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

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

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

→ **IF the Total Score for 18 and 19 = 0, Go to 25**

20) How often since your last in-person clinic visit have you found that you were not able to stop drinking once you had started?

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

21) How often since your last in-person clinic visit have you failed to do what was normally expected from you because of drinking?

- ☐ Never 0
- ☐ Less than monthly 1
- ☐ Monthly 2
- ☐ Weekly 3
- ☐ Daily or almost daily 4

22) How often since your last in-person clinic visit have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- ☐ Never 0
- ☐ Less than monthly 1
- ☐ Monthly 2
- ☐ Weekly 3
- ☐ Daily or almost daily 4

23) How often since your last in-person clinic visit have you had a feeling of guilt or remorse after drinking?

- ☐ Never 0
- ☐ Less than monthly 1
- ☐ Monthly 2
- ☐ Weekly 3
- ☐ Daily or almost daily 4

24) How often since your last in-person clinic visit have you been unable to remember what happened the night before because you had been drinking?

- ☐ Never 0
- ☐ Less than monthly 1
- ☐ Monthly 2
- ☐ Weekly 3
- ☐ Daily or almost daily 4

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

- ☐ No 0
- ☐ Yes, but not since your last in-person clinic visit 1
- ☐ Yes, since your last in-person clinic visit 2

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

- ☐ No 0
- ☐ Yes, but not since your last in-person clinic visit 1
- ☐ Yes, since your last in-person clinic visit 2

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27) Have you injected, snorted, or inhaled any substance(s) for non-medical purposes such as cocaine, heroin, methamphetamines, opiates, and glue (DO NOT include marijuana or tobacco-based substances) since your last in-person clinic visit?

	No$_0$	Yes$_1$
27a) Injected a substance	☐	☐
27b) Snorted a substance	☐	☐
27c) Smoked or inhaled a substance	☐	☐

→ **IF participant is MALE, Go to 34**

→ **IF participant is FEMALE, Continue with 28**

28) Have you reached menopause since your last in-person clinic visit?

☐ No$_0$ → **Go to 29**
☐ Yes$_1$
☐ Don't know$_2$ → **Go to 29**

28a) If you have reached menopause, at what age did that occur? ☐☐ years old

29) Have you used oral contraceptive medications since your last in-person clinic visit?

☐ No$_0$ → **Go to 30**
☐ Yes$_1$

29a) If you have used oral contraceptives, for how many years? ☐.☐ years

30) Have you used hormone replacement therapy since your last in-person clinic visit?

☐ No$_0$ → **Go to 31**
☐ Yes$_1$

30a) If you have used hormone replacement therapy, for how many years? ☐.☐ years

31) Since your last in-person clinic visit, have you been pregnant?

☐ No$_0$
☐ Yes$_1$

32) Since your last in-person clinic visit, did you ever breastfeed?

☐ No$_0$ → **Go to 33**
☐ Yes$_1$

32a) If you did breastfeed, for approximately how many total months did you breastfeed (*total for all pregnancies*)?

☐☐ months

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33) Have you had an ovary removed since your last in-person clinic visit?

- ☐ No$_0$ → **Go to 34**
- ☐ Yes$_1$

33a) If you had an ovary removed, was one removed or both?

- ☐ One$_1$
- ☐ Both$_2$

33b) At what age was your ovary or ovaries removed? ☐☐ years old

Now I am going to ask you some questions about your current health insurance coverage.

34) Do you currently have health insurance or health care coverage?

- ☐ No coverage of any type$_0$ → **End Form**
- ☐ Yes$_1$
- ☐ Don't know$_2$ → **Go to 35**
- ☐ Refused$_3$ → **Go to 35**

34a) What kinds of health insurance or health care coverage do you have? *(check all that apply)*

- 34a1) Private health insurance$_1$ ☐
- 34a2) Medicare$_2$ ☐
- 34a3) Medigap$_3$ ☐
- 34a4) Children's Health Insurance Program (CHIP)$_4$ ☐
- 34a5) Military related health care: TRICARE (CHAMPUS)/ VA health care/ CHAMP-VA$_5$ ☐
- 34a6) Indian Health Service$_6$ ☐
- 34a7) State-sponsored health plan$_7$ ☐
- 34a8) Other government program$_8$ ☐
- 34a9) Don't know$_9$ ☐

→ **IF participant is under 65 years of age, Go to 36.**

→ **IF participant is 65 years of age or older, Continue with 35, 35a, and 35b.**

35) Are you covered by Medicare?

- ☐ No$_0$ → **Go to 36**
- ☐ Yes$_1$
- ☐ Don't know$_2$ → **Go to 36**
- ☐ Refused$_3$ → **Go to 36**

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35a) What type of Medicare coverage do you have?

- ☐ Part A – hospital only$_1$
- ☐ Part B – medical only$_2$
- ☐ Both Part A and Part B$_3$
- ☐ Don't know$_4$
- ☐ Refused$_5$

35b) Are you enrolled in Medicare Part D, also known as the Medicare Prescription Drug Plan?

- ☐ No$_0$
- ☐ Yes$_1$
- ☐ Don't know$_2$
- ☐ Refused$_3$

36) There is a program called Medicaid that pays for health care for persons in need. Are you covered by Medicaid?

- ☐ No$_0$
- ☐ Yes$_1$
- ☐ Don't know$_2$
- ☐ Refused$_3$

END OF FORM

National Center for Health Statistics. (2024). 2024 National Health Interview Survey (NHIS) Questionnaire version 7. Retrieved from: https://www.cdc.gov/nchs/nhis/2024nhis.htm.