



47261



Interviewer (initials)

[ ][ ][ ]

COPD Gene ID

[ ][ ][ ][ ][ ][ ]

Month

[ ][ ]

Day

[ ][ ]

Year

[ ][ ][ ][ ]

Center (eg, NJC)

[ ][ ][ ]

### Medical History

1. In general, how would you describe your health?

- Excellent
- Very good
- Good
- Fair
- Poor

2. Have you ever been told by a physician that you have

	Yes	No
Bladder cancer	<input type="radio"/>	<input type="radio"/>
Breast cancer	<input type="radio"/>	<input type="radio"/>
Colon cancer	<input type="radio"/>	<input type="radio"/>
Lung cancer	<input type="radio"/>	<input type="radio"/>
Prostate cancer	<input type="radio"/>	<input type="radio"/>
Angina	<input type="radio"/>	<input type="radio"/>
Congestive heart failure	<input type="radio"/>	<input type="radio"/>
Coronary artery disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>
Pneumothorax (collapsed lung)	<input type="radio"/>	<input type="radio"/>
Heart attack (MI)	<input type="radio"/>	<input type="radio"/>
Blood clots (in legs or lungs)	<input type="radio"/>	<input type="radio"/>
Macular degeneration	<input type="radio"/>	<input type="radio"/>
Peripheral vascular disease	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>
TIA (transient ischemic attack)	<input type="radio"/>	<input type="radio"/>
Gastroesophageal reflux	<input type="radio"/>	<input type="radio"/>
Stomach ulcers	<input type="radio"/>	<input type="radio"/>
Compression fractures (in your back)	<input type="radio"/>	<input type="radio"/>
Hip fracture	<input type="radio"/>	<input type="radio"/>
Osteoarthritis	<input type="radio"/>	<input type="radio"/>
Osteoporosis (thin bones)	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>

Note: If subject does not know the answer to any of these, mark **No**.

3. Does stiffness or pain in your joints or bones limit your ability to walk?

- Yes
- No

4. Do you have chronic stiffness or pain in your back?

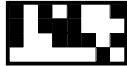
- Yes
- No

5. What limits your walking the most?

- Shortness of breath
- Leg or back discomfort
- Both
- Neither

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6. Have you had coronary artery bypass surgery (CABG)?

Yes  No

7. Have you had angioplasty or have you had cardiac stents placed?

Yes  No

8. Have you been tested for alpha-1 antitrypsin deficiency?

Yes  No  Uncertain

If **Yes**, what were the results?

Phenotype or genotype   Level    .  mg/dL  
   .  micromoles

Don't know

9. Do you currently smoke cigarettes?

Yes  No

If **Yes**, then answer the questions below.

a. On a typical day, how many cigarettes do you smoke?

1-10  11-20  21-30  31+

b. How soon after waking do you smoke your first cigarette?

Within 5 min  Between 6-30 min  Between 31-60 min  After 60 min

c. Do you smoke more during the first 2 hrs of the day than during the rest of the day?

Yes  No

d. Which cigarette would you hate most to give up?

First cigarette of the day  Any other cigarette of the day

e. Do you find it hard to not smoke in places where it is forbidden (for example, at work, in public buildings, on airplanes)?

Yes  No

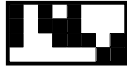
f. Do you smoke when you are so ill that you are in bed most of the day?

Yes  No

g. Do you now smoke or did you smoke menthol cigarettes?

Yes  No





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10. Do you have any joints that are painful, stiff, or aching ***most days of the month?***

Yes  No

If **Yes**, then mark all joints that apply.

- Shoulder
- Elbow
- Wrist or hand
- Hip, groin, or thigh
- Knee
- Foot or ankle

11. Do you have lower back, buttock, or radiating leg pain ***most days of the month?***

Yes  No

\* 12. Have you ever been told by a physician or health care provider that you have AIDS or that you have had a positive blood test for the HIV virus?

Yes  No

\* ***Answer only if have IRB approval to do so.***

