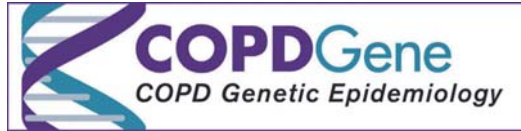




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Interviewer (initials)

□ □ □

COPD Gene ID

□ □ □ □ □ □ □ □

Month

□ □

Day

□ □

Year

□ □ □ □

Center (eg, NJC)

□ □ □ □

Nonsmoker Medical History

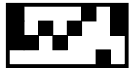
1. In general, how would you describe your health?

- Excellent
 Very good
 Good
 Fair
 Poor

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

	Yes	No	If Yes , age of diagnosis
Breast cancer	<input type="radio"/>	<input type="radio"/>	□ □
Prostate cancer	<input type="radio"/>	<input type="radio"/>	□ □
Colon cancer	<input type="radio"/>	<input type="radio"/>	□ □
Skin cancer (not melanoma)	<input type="radio"/>	<input type="radio"/>	□ □
Melanoma of the skin	<input type="radio"/>	<input type="radio"/>	□ □
Bladder cancer	<input type="radio"/>	<input type="radio"/>	□ □
Kidney cancer	<input type="radio"/>	<input type="radio"/>	□ □
Uterine cancer	<input type="radio"/>	<input type="radio"/>	□ □
Throat or mouth cancer	<input type="radio"/>	<input type="radio"/>	□ □
Ovarian cancer	<input type="radio"/>	<input type="radio"/>	□ □
Leukemia	<input type="radio"/>	<input type="radio"/>	□ □
Pancreatic cancer	<input type="radio"/>	<input type="radio"/>	□ □
Lymphoma	<input type="radio"/>	<input type="radio"/>	□ □
Other cancer _____	<input type="radio"/>	<input type="radio"/>	□ □
Pneumothorax (chest tube)	<input type="radio"/>	<input type="radio"/>	□ □
Angina	<input type="radio"/>	<input type="radio"/>	□ □
Atrial fibrillation	<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"/>	□ □
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"/>	□ □
Cognitive (memory) disorder	<input type="radio"/>	<input type="radio"/>	□ □





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COPDGene ID

Grid for COPDGene ID: 6 empty boxes

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

	Yes	No	If Yes , age of diagnosis
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Gastroesophageal reflux	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
HIV/AIDS	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Stomach ulcers	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Compression fractures (in your back)	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Connective tissue disease (lupus, scleroderma)	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Gout	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Hip fracture	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Osteoarthritis	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Osteoporosis (thin bones)	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/>

3. In the last 3 weeks, have you walked for exercise, biked, or used a treadmill at least twice a week?

Yes No

If **Yes**, then how many times a week have you exercised? times a week

And how many minutes at a time do you exercise? minutes

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

Yes No

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

Yes No

6. What limits your walking the most?

Shortness of breath Leg or back discomfort Both Neither

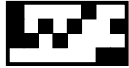
7. Have you had coronary artery bypass surgery (CABG)?

Yes No

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

Yes No





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COPDGene ID

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9. 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

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

Yes No

11. In the last year, did you ***unintentionally*** lose weight?

Yes No

If **Yes**, then how much weight did you lose? pounds

