Medical History

Please complete the survey below.

Thank you!

1. Since your last COPDGene visit, have you been told by a physician that you had ...
(Note: If you do not know the answer to any of these, mark NO.)

	Yes	No
Lung cancer	◯	◯
Breast cancer	◯	◯
Prostate cancer	◯	◯
Colon cancer	◯	◯
Skin Cancer (not melanoma)	◯	◯
Melanoma of the skin	◯	◯
Bladder cancer	◯	◯
Kidney cancer	◯	◯
Uterine cancer	◯	◯
Throat or mouth cancer	◯	◯
Ovarian cancer	◯	◯
Leukemia	◯	◯
Pancreatic cancer	◯	◯
Lymphoma	◯	◯
Other cancer	◯	◯

Cancer - Other (specify) _____

	Yes	No
Pneumothorax (collapsed lung, chest tube)	◯	◯

	Yes	No
Angina	◯	◯
Atrial fibrillation	◯	◯
Congestive heart failure	◯	◯
Coronary artery disease	◯	◯
High blood pressure	◯	◯
High cholesterol	◯	◯
Heart attack (MI)	◯	◯
Coronary artery bypass surgery	◯	◯

Angioplasty/cardiac stents	◯	◯

	Yes	No
Blood clots (in legs or lungs)	◯	◯
Macular degeneration	◯	◯
Peripheral vascular disease	◯	◯
Stroke	◯	◯
TIA (transient ischemic attack)	◯	◯

	Yes	No
Anemia	◯	◯
Diabetes	◯	◯
Gastroesophageal reflux	◯	◯
Stomach ulcers	◯	◯
HIV/AIDS	◯	◯
Kidney disease	◯	◯
Liver disease	◯	◯
Cognitive (memory) disorder	◯	◯

	Yes	No
Compression fractures (in your back)	◯	◯
Connective tissue disease (lupus, scleroderma)	◯	◯
Gout	◯	◯
Hip fracture	◯	◯
Osteoarthritis	◯	◯
Osteoporosis (thin bones)	◯	◯
Rheumatoid arthritis	◯	◯

2. Have you ever been told by a health care professional that you had ...

	Yes	No
Depression disorder	◯	◯
Anxiety disorder	◯	◯
Gum disease (periodontal disease, gingivitis)	◯	◯

3. Are you on kidney dialysis?	◯ Yes ◯ No
4. Since your last COPDGene visit, have you had any pulmonary rehabilitation?	◯ Yes ◯ No
a. If Yes, then in what year?	_____
5. In the last 3 weeks, have you walked for exercise, biked, or used a treadmill at least twice a week?	◯ Yes ◯ No

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

_____

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

_____

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

◯ Yes
◯ No

a. What limits your walking the most?

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

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

◯ Yes
◯ No

8. Do you have any joints (shoulder, elbow, wrist, hand, hip, groin, thigh, knee, foot or ankle) that are painful, stiff, or aching most days of the month?

◯ Yes
◯ No

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

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

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

◯ Yes
◯ No

If Yes to 9, answer a, b, and c.

a. Has this pain been present for 3 months or more?

◯ Yes
◯ No

b. Does the pain get better when you start moving or exercise?

◯ Yes
◯ No

c. Do you have definite stiffness in your joints when you get up in the morning?

◯ Yes
◯ No

10. In the last year did you unintentionally lose weight?

◯ Yes
◯ No

a. If Yes, then how much weight did you lose

_____
(pounds)

11. How often do you have a drink containing alcohol?

If Never is selected, do not ask a, b, c, or d.

◯ Never
◯ Monthly or less
◯ Two to four times a month
◯ Two to four times per week
◯ Four or more times per week

	Yes	No
a. Have you ever felt you needed to cut down on your drinking?	◯	◯
b. Have people annoyed you by criticizing your drinking?	◯	◯
c. Have you ever felt guilty about drinking?	◯	◯
d. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	◯	◯

Exhaustion and Fatigue

12. I feel that everything I do is an effort

◯ None of the time
◯ Some of the time (1-2 days per week)
◯ A moderate amount (3-4 days per week)
◯ Most of the time

13. I cannot get going

◯ None of the time
◯ Some of the time (1-2 days per week)
◯ A moderate amount (3-4 days per week)
◯ Most of the time

Females only:

14. Since your last COPDGene visit, have you become postmenopausal?

◯ Yes
◯ No
◯ Uncertain

a. How old were you when your periods stopped?

_____

15. Since your last COPDGene visit, have you used postmenopausal hormone replacement therapy?

◯ Yes
◯ No
◯ Uncertain

a. Have you used postmenopausal hormone replacement therapy within the last month?

◯ Yes
◯ No
◯ Uncertain

b. How long have you used postmenopausal hormone replacement therapy?

_____
(years)