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	◯	◯
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	◯	◯

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

3. Do you have any of your own teeth??
◯ Yes
◯ No

4. Are you on kidney dialysis?
◯ Yes
◯ No

5. Since your last COPDGene visit, have you had any pulmonary rehabilitation?
◯ Yes
◯ No

a. If Yes, in what year?
(Enter most recent year)
_____
(yyyy)

6. In the last 3 weeks, have you walked, biked, or used a treadmill for exercise at least twice a week?
◯ Yes
◯ No

a. If Yes, how many times a week have you exercised?	_____
b. How many minutes at a time do you exercise?	_____
7. 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
8. Do you have chronic stiffness or pain in your back?	◯ Yes ◯ No
9. 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
10. Do you have lower back, buttock, or radiating leg pain most days of the month?	◯ Yes ◯ No
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
11. In the last year did you unintentionally lose weight?	◯ Yes ◯ No
a. If Yes, how much weight did you lose	_____ (pounds)
12. How often do you have a drink containing alcohol?If Never is selected, go to #13	◯ 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?	◯	◯

13. Have you fallen in the past year?

◯ Yes
◯ No

If No, Go to #14.

a. How many times?

_____

b. Were you injured?

◯ Yes
◯ No

c. Were you hospitalized or in the emergency room?

◯ Yes
◯ No

d. Did you have a fracture?

◯ Yes
◯ No

Exhaustion and Fatigue

14. 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

15. 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:

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

◯ Yes
◯ No
◯ Uncertain

a. How old were you when your periods stopped?

_____

17. 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)