Multi-Ethnic Study of Atherosclerosis
Exam 5

COPD Questionnaire

Participant Id#:

Acrostic:

Date: ☐☐ / ☐☐ / ☐☐☐☐

The following are some questions about your <u>medical history</u>. Questions refer to things that happened since your last visit on _____. Please answer to the best of your knowledge.

1. Are you unable to walk due to a condition other than shortness of breath?

○ **Yes** → Nature of condition: ☐

○ No

2. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

○ **Yes** →

○ No

a. Do you have to walk slower than people of your age on level ground because of shortness of breath?

○ Yes ○ No ○ Does not apply

b.. Do you ever have to stop for breath when walking at your pace on level ground?

○ Yes ○ No ○ Does not apply

c.. Do you ever have to stop for breath when walking about 100 yards (or after a few minutes) on level ground?

○ Yes ○ No ○ Does not apply

d.. Are you too short of breath to leave the house or short of breath on dressing or undressing?

○ Yes ○ No ○ Does not apply

3. What limits your walking the most?

○ Shortness of breath ○ Both

○ Leg or back discomfort ○ Niether

4. In the past year, have you been to the emergency room or hospitalized for lung problems?

○ **Yes** → How many times? | | | |

○ No

5. In the past year, have you been treated with antibiotics for a chest illness?

○ **Yes** → How many times? | | | |

○ No

6. In the past year, have you been treated with steroid pills or injections, such as prednisone or solumedrol for chest illness?

○ **Yes** → How many times? | | | |

○ No

7. Since your last clinic visit, have you had to sleep on two or more pillows to help you breathe?

○ Yes ○ No ○ Don't Know

8. Are you taking a statin (for high cholesterol) on a regular basis?

○ Yes ○ No ○ Don't Know

9. Are you taking a high-dose fish oil supplement (eg. Lovaza) on a regular basis?

○ Yes ○ No ○ Don't Know

We would like to ask you some questions about issues that may be related to your <u>breathing</u>. Please answer to the best of your knowledge.

The following questions are about respiratory or chest symptoms. <u>If you are in doubt whether your answer is yes or no, please answer no.</u>

10. Have you ever had a problem with sneezing, or a runny or blocked nose when you did not have a cold or the flu?

○ Yes ○ No

11. Since your last visit with us, has a doctor ever told you that you had any of the following:

a. Pneumonia or bronchopneumonia?

- ○ **Yes** → How many times have you had pneumonia or bronchopneumonia since your last visit? ☐☐ times
- ○ No
- ○ Don't know

b. Chronic bronchitis?

- ○ **Yes** → Do you still have it? ○ Yes ○ No ○ Don't Know
- ○ No
- ○ Don't know

c. Other chest or lung illnesses, operations or injuries?

- ○ **Yes** → please specify: ☐
- ○ No
- ○ Don't know

d. Deep Vein Thrombosis (DVT)?

- ○ **Yes** → ☐☐ age ☐☐ # times
- ○ No

e. Pulmonary hypertension?

- ○ **Yes** → ☐☐ age onset
- ○ No

f. Cor pulmonale

- ○ **Yes** → ☐☐ age onset
- ○ No

The following questions are about your <u>smoking habits</u> (current and past).

12. Do you or did you smoke more during the first 2 hours of the day than during the rest of the day?

○ Yes ○ No

a. Which cigarette would you hate to or have hated most to give up?

○ First cigarette of the day ○ Any other cigarette of the day

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

○ Yes ○ No

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

○ Yes ○ No

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

○ Yes ○ No

13. Have you taken any inhalers, "puffers" or inhaled corticosteroids in the last three days (for example, alburetol (Ventolin, Proventil), salmeterol/fluticasone (Advair), ipratropium (Atrovent, Combivent), tiotropium (Spiriva), Aerobid, Azmacort, Beclovent, Flovent, Pulmicort, or Vanceril)?

○ **Yes** ○ No

Name of Medication	**Day that you last took?**	**Time that you last took?**
	○ Day before yesterday ○ Yesterday ○ Today	__ __ : __ __ ○ **M**
	○ Day before yesterday ○ Yesterday ○ Today	__ __ : __ __ ○ **M**
	○ Day before yesterday ○ Yesterday ○ Today	__ __ : __ __ ○ **M**
	○ Day before yesterday ○ Yesterday ○ Today	__ __ : __ __ ○ **M**

14. Do you usually use oxygen?

○ **Yes** → How many: __ __ hours/days __ __ L/minute

○ No

For MESA Field Center Use Only: Interviewer ID: ___ Reviewer ID: ___ Data Entry ID: ___

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