ALPHA-1 RESEARCH REGISTRY

QUESTIONNAIRE

Please answer the below questions to the best of your ability. You may want to ask your doctor or family members for help in answering some of the medical history questions.

If you have any questions, please contact the Alpha-1 Foundation at Tel# ___________________

Approved by HIRB on 03-26-2019
HIRB Version 2.0

Participant Information

Field	
First Name	________________________________
Last Name	________________________________
Maiden Name	________________________________
Date of Birth	________________________________
Age	________________________________
Street Address (Line 1)	________________________________
Street Address (Line 2)	________________________________
City	________________________________
State Zip	________________________________
Code	________________________________
Country	O USA O Other __________________
Home Phone Number	________________________________
Cell Phone Number	________________________________
Work Phone Number	________________________________
Email Address	________________________________

Preferred Method of Contact

O Phone
O Email
O Mail

Demographics

Race

O White
O American Indian or Alaska Native
O Asian
O Black or African American
O Native Hawaiian or Other Pacific Islander
O Other ________________________
O Prefer not to say

Ethnicity

O Hispanic or Latino
O Not Hispanic or Latino
O Prefer not to say

Gender

O Female
O Male
O Other _____________________
O Prefer not to say

Marital Status

O Single
O Married
O Separated
O Divorced
O Widowed
O Prefer not to say

Geographic History

Do you currently reside in the same City, State, and Country where you were born?

O Yes
O No

City where you were born. _________________________________

State where you wereborn. _________________________________

Country where you were born.

O Australia
O Canada
O USA
O Other
If other, list country _____________________

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Current Home/Living Location

O Farm
O Rural Area
O Suburban Area
O Urban Area
O Unknown

Number of people living in your household, including yourself.

____

How long have you lived at this location? (years)

____

What is your annual gross household income?

O Less than $10,000 (USD)
O $ 10,000-$ 24,999
O $ 25,000-$ 49,999
O $ 50,000-$ 74,999
O $ 75,000-$ 99,999
O $ 100,000-$ 149,999
O $ 150,000-$ 249,999
O $ 250,000 and above
O Prefer not to say

Insurance

Are you covered by any kind of health insurance or some other kind of health care plan?

O Yes
O No

Primary Health Insurance Type

O Private Health Insurance
O Medicare
O Medi-gap
O Medicaid
O SCHIP (children's health insurance program)
O Military Health Care (Tricare/VA, Champ/VA)
O Indian Health Service
O State Sponsored Health Plan
O Other Government Program
O Single Service Plan (e.g. Dental, Vision, Prescription)
O No Coverage
O Unknown

Have you been denied

O Yes

health care for insurance reasons?

O No

Job History

Have you ever been employed for a wage or salary, either part-time or full-time?

O Yes
O No

Which of the following best describes your current employment status?

O Working
O On leave but still employed
O Temporary laid off
O Unemployed and looking for work
O Unable to work
O Attending school
O Homemaker
O Retired
O Other

What is your longest held job/occupation?

____

What (is) (was) the kind of business or industry? (If necessary) What (do) (did) they make or do at this business?

____

What (are) (were) the usual activities or duties?

____

At what age did you first begin this job?

____

How many years, altogether, (have) (did) you work(ed) at this job?

____

On average, how many weeks per year (does)(did) you work at this job?

____

In the weeks you worked, how many hours per week (does)(did) you usually work?

____

In response to this job, are/were you

O Yes

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exposed to vapors, gas, dust or fumes?

O No
O Unknown

Which of these examples of vapors, gas, dust or fumes where you exposed to at work or other wise?

	Yes	No	Unknown
Irritant Gases (Such as Chlorine or Ammonia)	O	O	O
Fire, Smoke, or Other Combustion Products	O	O	O
Incinerators, Boilers, or Oil Refineries	O	O	O
Coal Dust or Powder	O	O	O
Silica, Sand, Concrete, or Cement Dust	O	O	O
Indoor Fuel Powered Motors, Compressors, or Engines	O	O	O
Diesel Engine Exhaust	O	O	O
Wheat Flour or Other Grain Dusts	O	O	O
Animal Feeds or Fodder	O	O	O
Cotton Dust or Cotton Processing	O	O	O
Wood or Saw Dust	O	O	O
Cadmium Fumes, Batteries, or Silver Solder	O	O	O
Other Metal Dusts or Metal fumes	O	O	O
Welding or Flame Cutting	O	O	O
Fiberglass or Other Man-made Mineral Fibers	O	O	O

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Explosive or Blasting Fumes	O	O	O

Aside from this job, have you worked in any other jobs that exposed him/her to vapors, gas, dust or fumes?

O Yes
O No
O Unknown

How many other jobs involved such exposures? ________________________________

How many years, altogether, did you work in this/these job(s)? ________________________________

At any of those jobs were you exposed to any of the following specific examples of vapors, gas, dust or fumes?

	Yes	No	Unknown
Irritant Gases (Such as Chlorine or Ammonia)	O	O	O
Fire, Smoke, or Other Combustion Products	O	O	O
Incinerators, Boilers, or Oil Refineries	O	O	O
Coal Dust or Powder	O	O	O
Silica, Sand, Concrete, or Cement Dust	O	O	O
Indoor Fuel Powered Motors, Compressors, or Engines	O	O	O
Diesel Engine Exhaust	O	O	O
Wheat Flour or Other Grain Dusts	O	O	O
Animal Feeds or Fodder	O	O	O
Cotton Dust or Cotton Processing	O	O	O

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Wood or Saw Dust	O	O	O
Cadmium Fumes, Batteries, or Silver Solder	O	O	O
Other Metal Dusts or Metal fumes	O	O	O
Welding or Flame Cutting	O	O	O
Fiberglass or Other Man-made Mineral Fibers	O	O	O
Explosive or Blasting Fumes	O	O	O

Considering all the jobs you have had, how many years of employment have they been regularly exposed to another person's cigarette smoke inside the workplace? Give the best estimate. ________________________________

Education

If you are less than 18 years old, what is the highest grade you completed?

O No schooling completed
O Preschool or Nursery school, kindergarten
O 1st Grade
O 2nd Grade
O 3rd Grade
O 4th Grade
O 5th Grade
O 6th Grade
O 7th Grade
O 8th Grade
O 9th Grade
O 10th Grade
O 11th Grade
O 12th Grade
O GED
O College
O N/A- I am 18 years or older

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If you are 18 years or older, what is the highest grade or level of school you have completed, or the highest degree you have received?

- O 8th Grade or less
- O More than 8th Grade, but did not graduate from high school
- O Went to business, trade, or vocational school instead of high school
- O High School Graduate
- O Completed a GED
- O Went to a business, trade, or vocational school after high school
- O Went to a college but did not graduate
- O Graduated from a college or university
- O Professional training beyond a 4 year college or university
- O Never went to school
- O N/A- I am younger than 18 years

What is the highest level of education your mother completed?

- O 8th Grade or less
- O More than 8th Grade, but did not graduate from high school
- O Went to business, trade, or vocational school instead of high school
- O High School Graduate
- O Completed a GED
- O Went to a business, trade, or vocational school after high school
- O Went to a college but did not graduate
- O Graduated from a college or university
- O Professional training beyond a 4 year college or university
- O Never went to school
- O Unknown

What is the highest level of education your father completed?

- O 8th Grade or less
- O More than 8th Grade, but did not from high school
- O Went to business, trade, or vocational school instead of high school
- O High School Graduate
- O Completed a GED
- O Went to a business, trade, or vocational

school after high school
O Went to a college but did not graduate
O Graduated from a college or university
O Professional training beyond a 4 year college or university
O Never went to school
O Unknown

Family History

Mother's First Name ________________________________

Mother's Maiden Name ________________________________

Mother's Last Name ________________________________

Mother's Date of Birth ________________________________

Father's First Name ________________________________

Father's Last Name ________________________________

Father's Date of Birth ________________________________

Which family members also are known to have Alpha-1 Antitrypsin Deficiency? Please list only tested individuals who are severely deficient (PiZZ, PiZnull, PiSZ, PiSnull). Check all that apply.

O None
O Daughter
O Granddaughter
O Grandson
O Half-brother
O Half-sister
O Maternal Aunt
O Maternal Cousin
O Maternal Grandfather
O Maternal Grandmother
O Maternal Uncle
O Brother
O Father
O Mother
O Sister
O Nephew
O Niece
O Paternal Aunt Paternal
O Cousin Paternal

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O Grandfather Paternal
O Grandmother
O Paternal Uncle
O Son
O Unknown
O Other ___________________________

How many brothers do you have from the same parents?

O 1
O 2
O 3
O 4
O 5
O 6
O 7
O 8
O 9
O 10 or more
O None

How many sisters do you have from the same parents?

O 1
O 2
O 3
O 4
O 5
O 6
O 7
O 8
O 9
O 10 or more
O None

Medical History

Part 1: Alpha-I Antitrypsin Deficiency (Alpha-I) History

What prompted you to have Alpha-1 testing done?

O Lung Symptoms
O Liver Symptoms
O Family Testing
O OtherScreening
O Other ____________________

What is your Alpha-I Genotype

O MS
O MZ
O MF
O SS
O SZ
O ZZ
O FZ
O FF
O Znull
O Mnull
O Snull
O Unknown
O Other ______________________________

Do you have your Alpha-1 testing report?

O Yes
O No

At what age did you begin to notice symptoms of Alpha-I?

____

Alpha-I Diagnosis Age?

____

Have you ever been admitted to a hospital due to Alpha-I?

O Yes
O No
O Unknown

How many times in the last 12 months have you been admitted to a hospital due to Alpha-1?

____

Have you had any surgeries as a result of Alpha-1?

O Yes
O No
O Unknown

Please list all surgeries that are applicable.

____

Have you been diagnosed with a fatty liver

O Yes

O No
O Unknown

Part 2: Lung History

♦ Section A: Asthma

Have you ever been diagnosed with Asthma? O Yes
O No (if NO, please skip to next section)

Year of Asthma Diagnosis ______________________________

Were you ever diagnosed with asthma as a child?
O Yes
O No
O Unknown
O Not Reported

At what age did you begin to notice childhood asthma symptoms? ______________________________

Asthma as an adult
O Yes
O No
O Unknown
O Not Reported

♦ Section B: Bronchiectasis

Have you ever been diagnosed with Bronchiectasis? O Yes
O No (if NO, please skip to next section)

Year of Bronchiectasis Diagnosis ______________________________

Year of Chronic Bronchitis Diagnosis ______________________________

♦ Section C: Chronic Obstructive Pulmonary Disease (COPD) and Emphysema

Have you ever been diagnosed with COPD? O Yes
O No

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Year of COPD Diagnosis ______________________ O N/A

Have you ever been diagnosed with Emphysema?
O Yes
O No

Year of Emphysema Diagnosis ______________________ O N/A

Number of exacerbations in the past year (defined by need for antibiotics or corticosteroids)? ______________________ O N/A

Number of exacerbations in the past year requiring ER or Hospital visits? ______________________ O N/A

♦ Section D: Other Lung related diagnosis

Have you ever had Hepatopulmonary Syndrome?
O Yes
O No

Year of Hepatopulmonary Syndrome Diagnosis ______________________

Have you ever been diagnosed with Lung Cancer?
O Yes
O No

Year of Lung Cancer Diagnosis ______________________

Have you ever been diagnosed with Portopulmonary Hypertension Diagnosis?
O Yes
O No

Year of Portopulmonary Hypertension Diagnosis ______________________

♦ Section E: Lung Surgical History

Have you ever had a Lung Transplant?
O Yes
O No

When was the date of the lung ______________________

transplant?

What hospital performed the lung transplant? __________________________________

Have you ever had a Lung Volume Reduction?
O Yes
O No

What was the date of the lung volume reduction? __________________________________

What hospital performed the lung volume reduction? __________________________________

Was the lung reduction performed by bronchoscopy or surgically?
O Bronchoscopic
O Surgery
O Unknown
O N/A

How was the bronchoscopic procedure performed?
O Valve
O Steam
O Chemical
O Coil
O Unknown
O N/A – never had bronchoscopy

- **Section F: Lung Tests**

Have you ever had an X-ray or CT scan of the lung?
O Yes
O No

When was the date of the most recent lung imaging? __________________________________ O N/A

Have you ever had a Pulmonary Function Test (PFT) done?
O Yes
O No

When was the date of the most recent PFT? __________________________________ O N/A

Part 3: Liver History

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- **Section A: Liver related Diagnosis**

Have you ever been diagnosed with Ascites?
O Yes
O No

Year of Ascites Diagnosis ______________________ O N/A

Have you ever been diagnosed with Cirrhosis?
O Yes
O No

Year of Cirrhosis Diagnosis ______________________ O N/A

Have you ever experienced symptoms of liver disease?
O Yes
O No

If YES, at what age did you begin to experience symptoms of liver disease? ______________________ O N/A

At what age were you clinically diagnosed with liver disease? ______________________ O N/A

Have you ever been diagnosed by a physician with any abnormal liver function tests?
O Yes
O No
O Not Tested
O Unknown

Were you ever diagnosed with childhood jaundice? If Yes, when did you begin to notice symptoms?
O Ist week of life
O 2nd week of life
O 3rd week of life
O I month
O After I month
O I did not have childhood jaundice
O I do not know if I had childhood jaundice
O Unknown

Have you ever been diagnosed with Cholestasis?
O Yes
O No

Year of Neonatal Cholestasis Diagnosis ______________________ O N/A

Have you ever been diagnosed with Non-alcoholic Steatohepatitis (NASH)?
O Yes
O No

Year of Non-alcoholic Steatohepatitis ______________________ O N/A

Have you ever been diagnosed with Panniculitis?
O Yes
O No

Year of Panniculitis Diagnosis ______________________ O N/A

Have you ever been diagnosed with Splenomegaly?
O Yes
O No

Year of Splenomegaly Diagnosis ______________________ O N/A

Have you ever been diagnosed with Spontaneous Bacterial Peritonitis Diagnosis?
O Yes
O No

Year of Spontaneous Bacterial Peritonitis Diagnosis ______________________ O N/A

Do you have a history of variceal bleeding?
O Yes
O No

Year of variceal bleeding diagnosis ______________________ O N/A

♦ Section B: Vaccinations

Have you received a vaccination for Hepatitis A?
O Yes
O No
O Unknown

Hepatitis A Vaccination Date ______________________ O N/A

Have you received a
O Yes

vaccination for Hepatitis B? — O No
O Unknown

Hepatitis B Vaccination Date ________________________________O N/A

Have you received a vaccination for Hepatitis C?
O Yes
O No

Hepatitis C Vaccination Date ________________________________O N/A

Have you been tested for HIV?
O Positive
O Negative
O Not Tested
O Unknown

HIV Test Date ________________________________O N/A

Have you ever been diagnosed with Hepatocellular Carcinoma (HCC)?
O Yes
O No

Year of Hepatocellular Carcinoma Diagnosis ________________________________O N/A

- **Section C: Liver Surgical History**

Have you ever had a Liver biopsy?
O Yes
O No

When was the date of the liver biopsy procedure? ________________________________O N/A

Have you had a Liver Transplant?
O Yes
O No

When was the date of the liver transplant procedure? ________________________________O N/A

What hospital performed the liver transplant? ________________________________O N/A

Have you had an endoscopy?
O Yes
O No

When was the date of the endoscopy? ________________________________. O N/A

- **Section E: Liver Imaging (radiology and ultrasound)**

Have you ever had an ultrasound or CT scan of the liver or abdomen?
O Yes
O No

When was the date of the most recent liver imaging? ________________________________O N/A

Part 4: Other Medical History

Have you been diagnosed with Diabetes?
O Yes
O No

Year of Diabetes Diagnosis ________________________________O N/A

Is Diabetes Insulin Requiring?
O Yes
O No

Have you had been diagnosed with? Gallstones?
O Yes
O No

Year of Gallstones Diagnosis ________________________________O N/A

Have you had bloodwork done?
O Yes
O No

What is the most recent date you had bloodwork done? ________________________________O N/A

Were you born at or close to your due date, how many weeks premature or after the due date were you?
O 2 weeks late
O 1 week late
O On time
O 1 week premature
O 2 weeks premature
O 3 weeks premature
O 4 weeks premature
O 5 weeks premature

O 6 weeks premature
O 7 weeks premature
O 8 weeks premature
O 9 weeks premature
O 10 weeks premature
O 11 weeks premature
O 12 weeks premature
O 13 weeks premature
O 14 weeks premature
O 15 weeks premature
O Unknown

Have you had any of the following:

O Myocardial infarct
O Congestive heart failure
O Peripheral vascular disease
O Cerebrovascular disease (except hemiplegia)
O Dementia
O Chronic pulmonary disease
O Connective tissue disease
O Ulcer disease (
O Mild liver disease
O Diabetes (without complications)
O N/A

Have you had any of the following:

O Diabetes with end organ damage
O Hemiplegia
O Moderate or severe renal disease
O Solid tumor (non metastatic)
O Leukemia
O Lymphoma, Multiple myeloma
O N/A

Have you had any of following:

O Moderate or severe liver disease the
O Metastatic solid tumor
O AIDS
O N/A

Medication History

	Currently	In The Past	Never
Beta-Agonists (Ex. Albuterol)	O	O	O
Oral Corticosteroids (Ex. Prednisone)	O	O	O

Inhaled Corticosteroids (Ex. Flovent, Advair, Symbicort)	O	O	O
Aspirin	O	O	O
Statin – drugs to lower cholesterol	O	O	O
Non-Steroidal Anti-Inflammatory Drug (NSAID) (Ex. Celebrex, Ibuprofen)	O	O	O
Augmentation (Infusion) Therapy	O	O	O
Oxygen	O	O	O
Anticholinergics (Ex. Spiriva)	O	O	O

List any other medications you are currently taking along with the dosage and frequency (e.g., Tylenol, 100mg, once a week)

____

____

____

____

____

____

Do you take any medical foods or follow a special diet for treatment of Alpha-1 Antitrypsin Deficiency?

O Yes
O No
O Not regularly

Hospitalization History

Please indicate if you were hospitalized in the last year

O Yes
O No (If NO, please skip to next section)

- First Hospitalization

Type of visit

O In-patient
O Emergency

Date of Hospitalization ______________________

Cause of Hospitalization ________________________________

Please indicate if a second hospitalization occurred in the last year?
O Yes
O No (If NO, please skip to next section)

- Second Hospitalization

Type of visit
O In-patient
O Emergency

Date of Hospitalization ________________________________

Cause of Hospitalization ________________________________

Please indicate if a third hospitalization occurred in the last year?
O Yes
O No (If NO, please skip to next section)

- Third Hospitalization

Type of visit
O In-patient
O Emergency

Date of Hospitalization ________________________________

Cause of Hospitalization ________________________________

Please indicate if a fourth hospitalization occurred in the last year?
O Yes
O No (If NO, please skip to next section)

- Fourth Hospitalization

Type of visit
O In-patient
O Emergency

Date of Hospitalization ________________________________

Cause of Hospitalization ________________________________

Please indicate if a fifth hospitalization occurred in the last year?	O Yes O No (If NO, please skip to next section)

- Fifth Hospitalization

Type of visit	O In-patient O Emergency
Date of Hospitalization	______________________________
Cause of Hospitalization	______________________________

Smoking History

Have you ever smoked in your lifetime?	O Yes (continue with below section) O No (skip to next section)
Current Smoking Status	O Non-smoker O Current smoker O Ex-smoker (Note: <100 cigarettes in a lifetime defines a non-smoker)
At what age did you start smoking?	______________________________
At what age did you stop smoking?	______________________________
Average cigarettes per day?	______________________________ (Note: 1 pack = 20 cigarettes)
Were you exposed to second-hand smoke as a child (age 12 or younger) for at least one year?	O Yes O No O Unknown
Were you exposed to second-hand smoke after age 12 for at least one year?	O Yes O No O Unknown

Does anyone in your household currently smoke?	O Yes O No O Unknown

Alcohol History

I am	O Lifetime abstainer from alcohol O Former alcohol consumer (no alcohol consumed in the past 12 months) O Current alcohol consumer (consumed alcohol in the last 12 months, i.e., socially) O Unknown

How many drinks containing alcohol do you consume each day? _______________

The following are a set of validated questionnaires that will ask you about alcohol, COPD and quality of life.

Alcohol Use Disorder Identification Test (AUDIT-C) - Questionnaire

If you are a current alcohol consumer (consumed alcohol in the past 12 months), please answer the following questions. If not, please continue to the next section entitled Family History

How often do you have a drink containing alcohol?	O Never O Monthly or less O 2-4 times a month O 2-3 times a week O 4 or more times a week
How many standard drinks containing alcohol do you have on a typical day?	O 1 or 2 O 3 or 4

	O 5 or 6 O 7 to 9 O 10 or more
How often do you have 6 or more drinks on one occasion?	O Never O Less than monthly O Monthly O Weekly O Daily or almost daily

St. Georges Respiratory Questionnaire (SGRQ)

ORIGINAL ENGLISH VERSION

This questionnaire is designed to help us learn much more about how your breathing is troubling you and how it affects your life. We are using it to find out which aspects of your illness cause you most problems, rather than what the doctors and nurses think your problems are. Please read the instructions carefully and contact us if you do not understand anything. Do not spend too long deciding about your answers.

The questions below are about how much chest trouble you have had over the past 3 months. Please tick one circle for each question:

Before completing the rest of the questionnaire:

Please choose one to show how you describe your current health:	O Very good O Good O Fair Poor O Very Poor

St. George's Respiratory Questionnaire PART 1

1. Over the past 3 months, I have coughed: Please select one:	O most days a week O several days a week O a few days a month O only with chest infections O not at all
2. Over the past 3 months, I have brought up phlegm (sputum): Please select one:	O most days a week O several days a week O a few days a month O only with chest infections

O not at all

3. Over the past 3 months, I have had shortness of breath:
Please select one:

O most days a week
O several days a week
O a few days a month
O only with chest infections
O not at all

4. Over the past 3 months, I have had attacks of wheezing:
Please select one:

O most days a week
O several days a week
O a few days a month
O only with chest infections
O not at all

5. Over the past 3 months how many severe or very unpleasant attacks of chest trouble have you had?
Please select one:

O more than 3 attacks
O 3 attacks
O 2 attacks
O 1 attack
O not at all

6. How long did the worst attack of chest trouble last?
(Go to question 7 if you had no severe attacks)

Please select one:

O a week or more
O 3 or more days
O 1 or 2 days
O less than a day

7. Over the past 3 months, in an average week, how many good days (with little chest trouble) have you had?

O No good days
O 1 or 2 good days
O 3 or 4 good days
O nearly every day is good
O every day is good

8. If you have a wheeze, is it worse in the morning?

O Yes
O No

St. George's Respiratory Questionnaire PART 2

Section 1
9. How would you describe your chest condition?
Please select one:

O The most important problem I have
O Causes me quite a lot of problems
O Causes me a few problems
O Causes no problem

10. If you have ever had paid employment. Please select one:	O My chest trouble made me stop work altogether O My chest trouble interferes with my work or made me change my work O My chest trouble does not affect my work

Section 2

The following questions are about activities that may make you feel breathless these days. Please select True for any that make you feel breathless these days. Please select false for any statements that do not make you feel breathless these days:

11a. Sitting or lying still	O True O False
11b. Getting washed or dressed	O True O False
11c. Walking around the home	O True O False
11d. Walking outside on the level	O True O False
11e. Walking up a flight of stairs	O True O False
11f. Walking up hills	O True O False
11g. Playing sports or games	O True O False

Section 3

The following questions are about your cough and breathlessness these days. Please select True for any statement that is accurate these days. Please select false for any statements that are inaccurate.

12a. My cough hurts	O True O False
12b. My cough makes me tired	O True O False
12c. I am breathless when I talk	O True O False

12d. I am breathless when I bend over
O True
O False

12e. My cough or breathing disturbs my sleep
O True
O False

12f. I get exhausted easily
O True
O False

Section 4

The following questions are about other effects that your chest trouble may have on you these days. Please select True for any statement that applies. Please select False for any statement that does not apply.

13a. My cough or breathing is embarrassing in public
O True
O False

13b. My chest trouble is a nuisance to my family, friends or neighbors
O True
O False

13c. I get afraid or panic when I cannot get my breath
O True
O False

13d. I feel that I am not in control of my chest problem
O True
O False

13e. I do not expect my chest to get any better
O True
O False

13f. I have become frail or an invalid because of my chest
O True
O False

13g. Exercise is not safe for me
O True
O False

13h. Everything seems too much of an effort
O True
O False

14. Questions about your medication.
If no medications are being taken, answer "none" for 14a and then false for 14b-14e.

14a. I am not taking any medications
O None

14b. My medication does not help me very much
O True
O False

14c. I get embarrassed using my medication in public
O True
O False

14d. I have unpleasant side effects from my medication
O True
O False

14e. My medication interferes with my life a lot
O True
O False

Section 6

The following questions are about how your activities might be affected by your breathing. Please select True for any statement that applies to you because of your breathing. Please select False for any statement that applies to you because of your breathing.

15a. I take a long time to get washed or dressed
O True
O False

15b. I cannot take a bath or shower, or I take a long time
O True
O False

15c. I walk more slowly than other people, or stop for rests
O True
O False

15d. Jobs such as housework take a long time, or I have to stop for rests
O True
O False

15e. If I walk up one flight of stairs, I have to go slowly or stop
O True
O False

15f. If I hurry or walk fast, I have to stop or slow down
O True
O False

15g. My breaking makes it difficult to do things such as walk up hills, carry things up stairs, light gardening such as weeding, dance, play bowls or play golf
O True
O False

15h. My breaking makes it difficult to do things such as carry heavy loads, dig the garden or shovel snow, jog or walk at 5 miles per hour, play tennis or swim
O True
O False

15i. My breathing makes it difficult
O True

to do things such as very heavy manual work, run, cycle, swim fast or play competitive sports
O False

Section 7

The following questions pertain to how your chest usually affects your daily life. Please select True for any statement that applies to you because of your chest trouble:

16a. I cannot play sports or games
O True
O False

16b. I cannot go out for entertainment or recreation
O True
O False

16c. I cannot go out of the house to do the shopping
O True
O False

16d. I cannot do housework
O True
O False

16e. I cannot move far from my bed or chair
O True
O False

17. Which statement best describes how your chest affects you
O It does not stop me from doing anything I would like to do
O It stops me from doing one or two things I would like to do
O It stops me from doing most of the things I like to do
O It stops me from doing everything I would like to do

Here is list of other activities that your chest trouble may prevent you doing. (You do not have to select these, they are just to remind you of ways in which your breathlessness may affect you):

-Going for walks or walking the dog
-Doing things at home or in the garden
-Sexual intercourse
-Going out to church, pub, club or place of entertainment
-Going out in bad weather or into smoky rooms
-Visiting family or friends or playing with children

Please write in any important activities that your chest

trouble may stop you from doing: ________________________________

____

COPD Assessment Test (CAT) - Questionnaire

	0	**1**	**2**	**3**	**4**	**5**
How often do you cough, with 0 being never and 5 coughing all the time?	O	O	O	O	O	O
How much phlegm (mucus) do you have in your chest, with 0 being that you have no phlegm (mucus) in your chest at all and 5 chest is completely full of phlegm (mucus)?	O	O	O	O	O	O
How tight does your chest feel, with 0 being not tight at all and 5 chest feels very tight?	O	O	O	O	O	O
Do you feel breathless when walking up a hill or one flight of stairs, with 0 being not breathless and 5 being very breathless?	O	O	O	O	O	O
How limited are you when doing activities at home, with 0 being not limited and 5 very limited?	O	O	O	O	O	O
How confident do you feel leaving your home with your lung condition, with 0 being not limited and 5 very limited?	O	O	O	O	O	O
How do you sleep, with 0 being that you sleep soundly and 5 you don't sleep soundly because of your lung condition?	O	O	O	O	O	O
How much energy do you have,	O	O	O	O	O	O

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with 0 being lots of energy and
5 no energy at all.

General Health

In general, how would you describe your overall health?

O Excellent
O Very good
O Good
O Fair
O Poor

Does your health now limit you in doing vigorous activities?

O Not at all
O Very little
O Somewhat
O Quite a lot
O Cannot do

How much does pain interfere with your enjoyment of life?

O Not at all
O A little bit
O Somewhat
O Quite a bit
O Very much

How often do you feel tired?

O Never
O Rarely
O Sometimes
O Often
O Always

How often do you feel depressed?

O Never
O Rarely
O Sometimes
O Often
O Always

Do you use any assistive devices? (such as wheelchairs, hearing aids, ramps, prosthetic devices)

OYes
O No

If yes, can you specify the type of assistive devices you use ______________________

Providers and Facilities

Once you have completed the questionnaire, we will ask you to provide the following labs and test results from your medical records. In the section below, please list where you have had the most recent following exams performed:

The last five 6 Minute Walk Test:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

The Last five Pulmonary Function Test:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

The Last five Bloodwork:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

The last five Lung and/ or Liver Ultrasound:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

The last 5 lung Fibro scan:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Thank you for filling in this questionnaire. Before you finish would you please check to see that you have answered all the questions and list out the provider and facility information of where your medical tests and labs were performed.

Thank you for your participation!

We will make follow up calls everyone to two years to update any medical care changes and request any new relevant test results.

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