EXACERBATION ASSESSMENT FORM

ID NUMBER:									FORM CODE: **EAF** VERSION: **1.0** 05/27/14	Visit Number			SEQ #		

0a) Form Completion Date.... ☐☐/☐☐/☐☐☐☐ 0b) Staff Code ..... ☐☐☐

Instructions: *This form should be completed when a participant comes to the clinical center for an exacerbation study visit. This form should be completed before proceeding with the rest of the study visit.*

Administrative Information

1) Date of clinic visit: ☐☐/☐☐/☐☐☐☐

2) What type of Event is this? ..... ☐

Participant/HCU-triggered 1
Symptom/EXACT-Triggered 2

Examination (completed by Coordinator):

3) Temperature ☐☐☐.☐ °C

4) Weight ☐☐☐.☐ kg

5) Pulse ☐☐☐ min^{-1}

6) Sp02 ☐☐☐ %

7) Notes:

Participant Interview (completed by Coordinator):

8) Have you had any changes to your **respiratory** medications related to this event (this includes new prescriptions or self-medication)? ..... ☐

Yes 1

No ..... 0→**Go to 12**

Please specify type of medication for this event by checking the appropriate box:

9) MEDICATION	Date Prescribed	Duration (Days)
a1) Antibiotic 1:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
a2) Antibiotic 2:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
b1) Inhaled corticosteroids:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
c1) Inhaled corticosteroids w/long-acting ß$_2$-agonists:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
d1) Aminophyllines:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
e1) ß$_2$-agonists Short-Acting:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
f1) ß$_2$-agonists Long-Acting:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
g1) Short-acting anticholinergic_____	☐☐/☐☐/☐☐☐☐	☐☐☐
h1) Long-acting anticholinergic_____	☐☐/☐☐/☐☐☐☐	☐☐☐
i1)Short-acting ß$_2$-agonists/anticholinergic:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
j1) Long-acting ß$_2$-agonists/anticholinergic:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
k1) Roflumilast (Daxas, Daliresp) (Y/N): ☐	☐☐/☐☐/☐☐☐☐	☐☐☐
l1) Leukotriene antagonists:_____	☐☐/☐☐/☐☐☐☐	☐☐☐
m1) Other Medications: (Y/N): ☐		
Specify:_____	☐☐/☐☐/☐☐☐☐	☐☐☐

10) TREATMENTS	Date Prescribed	Duration (Days)
a) Pulmonary Rehabilitation (Y/N): ☐	☐☐/☐☐/☐☐☐☐	☐☐☐
b) Supplemental Oxygen (Y/N): ☐	☐☐/☐☐/☐☐☐☐	☐☐☐
c) Other Clinical Treatments (Y/N): ☐		
Specify:_____	☐☐/☐☐/☐☐☐☐	☐☐☐

11) Have you had a new or changed prescription for oral steroids as a result of the change in your respiratory symptoms? ☐

Yes 1

No..... 0→**Go to 12**

11a) What type of oral steroids were prescribed? _____

11a1) Specify:_____

11b) What date were the oral steroids prescribed? ☐☐/☐☐/☐☐☐☐

11c) What is the duration of this prescription? ☐☐☐ days

11d) What was the total dosage of oral steroids prescribed? ☐☐☐ mg

12) Have you taken any pain medications such as aspirin, Advil, Aleve, or Tylenol? ☐

Yes 1

No..... 0→**Go to 13**

12a) Pain medicine 1:_____

12a1) Specify:_____

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
☐☐/☐☐/☐☐☐☐			☐☐☐

12b) Pain medicine 2:_____

12b1) Specify:_____

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
☐☐/☐☐/☐☐☐☐			☐☐☐

12c) Pain medicine 3:_____

12c1) Specify:_____

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
☐☐/☐☐/☐☐☐☐			☐☐☐

12d) Pain medicine 4:_____

12d1) Specify:_____

Date Started	Dose Taken (mg)	Times per day (1-6 or >6)	Duration (Days)
☐☐/☐☐/☐☐☐☐			☐☐☐

Review of Symptoms (Completed by Coordinator)

13) How serious is this flare-up/exacerbation compared to previous flare ups/exacerbations? ☐

More serious 1
As serious 2
Less serious 3
Never had an exacerbation before 4

14) Since the start or worsening of your symptoms, have you experienced any of the following for at least 2 or more consecutive days?

	Yes	No
a) Increase or Worsening in Shortness of Breath (Dyspnea)	☐	☐
b) Change in sputum color (purulence).....	☐	☐
c) Increase in sputum volume.....	☐	☐

15) Since the start or worsening of your symptoms, have you experienced any of the following for at least 2 or more consecutive days?

	Yes	No
a) Runny Nose/Nasal discharge	☐	☐
b) Increase or worsening of Wheeze	☐	☐
c) Sore throat.....	☐	☐
d) Increase or worsening of Cough.....	☐	☐
e) Fever	☐	☐

16) Have you had any OTHER **new** Symptoms related to this event? ☐

Yes 1

No ..... 0→**Go to 17**

a) Symptom 1: _____

b) Symptom 2: _____

c) Symptom 3: _____

d) Symptom 4: _____

e) Symptom 5: _____

f) Symptom 6: _____

g) Symptom 7: _____

h) Symptom 8: _____

i) Symptom 9: _____

j) Symptom 10: _____

Physician Assessment

17) Wheezes:
☐ Yes
☐ No

18) Crackles:
☐ Yes
☐ No

19) Gallop:
☐ Yes
☐ No

20) Edema:
☐ Yes
☐ No

21) Were other conditions present at the time of this event? (Y/N) ☐ → If no skip to 23

22) If yes, please specify the conditions present:

a) Pneumonia:
☐ Yes
☐ No→Go to 22c

b) Pneumonia confirmed by:
☐ Chest film
☐ Clinical examination
☐ Both

c) Congestive Heart Failure:
☐ Yes
☐ No

d) Other:
☐ Yes
☐ No
Specify:_____

e) Other:
☐ Yes
☐ No
☐ Specify:_____

f) Other:
☐ Yes
☐ No
Specify:_____

23) Diagnosis of a COPD exacerbation:
☐ Yes
☐ No → **Skip to Q29**

24) Exacerbation severity:
☐ Mild
☐ Moderate
☐ Severe
☐ Very Severe

25) Duration to date:
☐ Less than 1 Day
☐ 1-2 Days
☐ 3-5 Days
☐ 1 Week
☐ More than 1 Week
☐ Unknown

26) Potential Etiology:
☐ Infectious **(answer Q27)**
☐ Weather
☐ Treatment Non-Compliance
☐ Air pollution
☐ Unknown

27) Potential Infectious Etiology:
☐ Viral
☐ Bacterial
☐ Unknown
☐ Other (specify):
_____

28) Participant to proceed with exacerbation visit?
☐ Yes → **END**
☐ No
☐ Not COPD exacerbation
☐ Outside of visit window (> 72 hrs)
☐ Other
Specify:_____
→ **END (Do not proceed to Q29 or 30)**

29) If not a COPD exacerbation, what:
☐ Lack of symptomatic criteria
☐ Upper respiratory tract infection
☐ Change in comorbid condition →**Go to Q28**
☐ Other
Specify:_____

30) Change(s) in what comorbid condition (s)?
☐ Cardiovascular (Angina, CHF, etc)
☐ Neurological
☐ Other
Specify:_____