SOURCE
SPIROMICS Study of Early COPD Progression

FOLLOW-UP MEDICATION USE QUESTIONNAIRE

ID NUMBER:									

FORM CODE: MEF
VERSION: 1.0 10/21/2022

Event: _____

0a) Date of Collection: ☐☐ / ☐☐ / ☐☐☐☐ 0b) Staff Code: ☐☐☐

Instructions: *This form should be completed during the participant's 18-month follow-up phone call and 3-year follow-up clinic visit. Initially, list all non-study medications that the participant is currently taking with regularity. Do NOT list medications that are taken "as needed" (PRN), unless they are taken at least once per week.*

Notes:

- *For the 18-month follow-up phone call, all questions should be answered thinking back to the baseline visit as the last SOURCE contact.*
- *For the 3-year follow-up clinic visit, all questions should be answered thinking back to the 18-month follow-up phone call as the last SOURCE contact.*

1) Are you regularly using any medication(s)?

☐ No$_0$ → **Go to 15**

☐ Yes$_1$

1a) Total number of medications: ☐☐

NOTE: Pull the previous list of medications recorded (i.e., previously entered MED or MEF) during the participant's last SOURCE clinic visit or phone call and review with the participant. Enter all previously recorded medication(s), if applicable, and any new medication(s) the participant is taking with regularity.

MEDICATION RECORD

*Begin entering the **Coded Medication Name** into **item (a)** and select the matching medication name (and dosage, if known). If the medication name is not found in the coding dictionary, enter the **Uncoded Medication Name** into **item (b)**. Enter the dosage **Strength** and **Units** in **item (c)** and **item (d)**, respectively, for all uncoded medications.*

2)	(a) Coded Medication Name		
	(b) Uncoded Medication Name	(c) Strength	(d) Units

3)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
4)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
5)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
6)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
7)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**

8)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
9)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
10)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
11)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
12)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**

13)	(a) Coded Medication Name		
	(b) Uncoded Medication Name	(c) Strength	(d) Units

14) Are any of the medications you take for: *(If Yes, verify that the **Medication Name** is on the medication record.)*

	No$_0$	Yes$_1$	Don't know$_2$
14a) Asthma	☐	☐	☐
14b) Chronic bronchitis or emphysema	☐	☐	☐
14c) High blood sugar or diabetes	☐	☐	☐
14d) High blood pressure or hypertension	☐	☐	☐
14e) High blood cholesterol	☐	☐	☐
14f) Chest pain or angina	☐	☐	☐
14g) Abnormal heart rhythm	☐	☐	☐
14h) Heart failure	☐	☐	☐
14i) Blood thinning	☐	☐	☐
14j) Stroke	☐	☐	☐
14k) Mini-stroke or TIA	☐	☐	☐
14l) Leg pain while walking or claudication	☐	☐	☐
14m) Other	☐	☐	☐

14m1) Please specify other: _____

15) Are you currently using supplemental oxygen (prescribed by your doctor) at home?

☐ No$_0$ → **Go to 16**

☐ Yes$_1$

15a) Approximately how many hours in a 24-hour period do you use oxygen? ☐☐ hours

15b) If you are using nighttime supplemental oxygen, do you use oxygen only at night?

- ☐ No$_0$
- ☐ Yes$_1$

16) Are you currently using or have you used nicotine replacement therapy (gum, patch, lozenge, or spray)?

- ☐ No, have never used$_0$
- ☐ Yes, currently using$_1$
- ☐ Yes, have used in the past, but not currently using$_2$

17) Are you currently using or have you used a prescription medication for tobacco cessation?

- ☐ No, have never used$_0$
- ☐ Yes, have used in the past, but not currently using$_1$
- ☐ Yes, currently using Chantix (varenicline)$_2$
- ☐ Yes, currently using Zyban (bupropion)$_3$

18) Are you currently using any oral antioxidant supplements (listed below)?

- ☐ No$_0$ → **Go to 19**
- ☐ Yes$_1$

If Yes, please indicate which supplement(s) you use regularly? *(check all that apply)*

- 18a) ☐ Vitamin A (beta carotene)
- 18b) ☐ Vitamin C (ascorbic acid)
- 18c) ☐ Vitamin D (cholecalciferol)
- 18d) ☐ Vitamin E (alpha-tocopherol)
- 18e) ☐ Zinc
- 18f) ☐ Copper
- 18g) ☐ Fish oil
- 18h) ☐ Omega 3
- 18i) ☐ Other

18i1) Please specify other: _____

19) Are you currently using or have you used any other medications (prescribed or over the counter) or supplements regularly that are not listed above?

☐ No$_0$ → **Go to End**

☐ Yes$_1$

If Yes, please list any other medications (prescribed or over the counter) or supplements not listed above:

19a) _____

19b) _____

19c) _____

19d) _____

19e) _____

END OF FORM