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11. How many children do you have (including adopted or children you have raised)?
12. Do you have difficulties in carrying out the daily activities by yourself?
 None A little Some Quite a lot Cannot do, need help
13. Who is doing the necessary care personal you need?
 Myself
 Partner/wife/husband
 Son/daughter
 Other relatives
 Social services
 Housekeeper/private care
 Neighbour/friend
 Other
14. Is a partner/ husband/ wife/ father/ mother or another person living with you in need of care? Yes No
 [If "YES" go to question 15, if "NO" go to question 16]
15. If YES, do you participate in his/ her care?
 Yes, I take the complete care
 Yes, I take a bigger part, but get supported
 Yes, I take a smaller part, get strongly supported
 No, care is completely done by others
 No response
16. At your home, who is doing the tasks such as cooking, ironing, cleaning, etc.?
 Myself
 My wife/husband
 Myself, shared with my wife/husband/relative
 Another person living at home (bnot wife/husband)
 Another contact person
 Social services

CD Asthma and COPD related symptoms and diagnostic

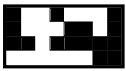
Wheezing/ Whistling

1. Have you had wheezing or whistling in your chest at any time in the last 12 months? Yes No
 [If "YES", ask both Questions 1A,1B, 1C & 1D; If "NO", skip to Question 2]
- 1A. In the last 12 months, have you had this wheezing or whistling only when you have a cold? Yes No
- 1B. In the last 12 months, have you ever had an attack of wheezing or whistling that has made you feel short of breath? Yes No
- 1C. Are there any month in which you have wheezing or whistling on most days? Yes No
- 1D. If 'Yes', indicate the months you have it most days:
 January February March April May June
 July August September October November December

Breathlessness

2. Are you unable to walk due to a condition/ health problem other than shortness of breath? Yes No
 [If 'Yes' to Question 2, please describe this condition/ health problem on the line below in question 2A. If "NO" or unsure, go directly to Question 3.]

2A. Nature of condition(s):



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3. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? Yes No

[If 'YES', ask Question 3A through 3D; If "NO", skip to Question 4]

3A. Do you have to walk slower than people of your age on level ground because of shortness of breath? Yes No

3B. Do you ever have to stop for breath when walking at your own pace on level ground? Yes No

3C. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on level ground? Yes No

3D. Are you too short of breath to leave the house or short of breath on dressing or undressing? Yes No

4. Have you been woken by an attack of shortness of breath at any time during the last 12 months? Yes No

Cough

5. Do you usually cough when you don't have a cold? Yes No

[If "YES", continue with Question 5A; If "NO", skip to Question 6]

5A. Are there months in which you cough on most days? Yes No

[If "YES", ask both Questions 5B & 5C; If "NO", skip to Question 6]

5B. Do you cough on most days for as much as three months each year? Yes No

5C. For how many years have you had this cough? < than 2 years 2-5 years > than 5 years

6. Have you been woken up by an attack of coughing at any time in the last 12 months? Yes No

Phlegm

7. Do you usually bring up phlegm from your chest, or do you usually have phlegm in your chest that is difficult to bring up when you don't have a cold? Yes No

[If "YES", continue with Question 7A; If "NO", skip to Question 8]

7A. Are there months in which you have this phlegm on most days? Yes No

[If "YES", ask both Questions 7B & 7C; If "NO", skip to Question 8]

7B. Do you bring up this phlegm on most days for as much as three months each year? Yes No

7C. For how many years have you had this phlegm? < than 2 years 2-5 years > than 5 years

Allergies

8. Do you have any nasal allergies, including hay fever? Yes No

[If "YES", continue with Question 8A; If "NO", skip to Question 9]

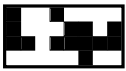
8A. How old were you when you first had hay fever or nasal allergy? Years

9. 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

[If "YES", continue with Question 9A; If "NO", skip to Question 10]

9A. Have you ever had a problem with sneezing or a runny or blocked nose when you did not have a cold or the flu in the last 12 months? Yes No

[If "YES", continue with Question 9A1 and 9A2; If "NO", skip to Question 10]



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9A1 . Has the nose problem been accompanied by itchy or watery eyes? Yes No

9A2. In which months of the year did this nose problem occur?

- January February March April May June
- July August September October November December

10. Have you used any medication to treat nasal disorders? Yes No

11. Have you ever had eczema or any kind of skin allergy? Yes No

12 Have you ever had an itchy rash that was coming and going for at least 6 months? Yes No

[If 'YES', continue with question 12A; If 'NO', skip to question 13]

12A. Have you had this itchy rash in the last 12 months? Yes No

[If 'YES', continue with question 12A1; If "NO", skip to question 13]

12A1. Has this itchy rash at any time affected any of the following places:
the folds of the elbows, behind the knees, in front of the ankles
under the buttocks or around the neck, ears or eyes Yes No

Sleep apnea (Berlin questionnaire)

13. Do you snore? Yes No Don't know

[If 'YES', ask Questions 14 to 22; If 'NO' or 'Don't know', skip to Question 18]

14. Your snoring is?

- Slightly louder than breathing
- As loud as talking
- Louder than talking
- Very loud
- Don't know

15. How often do you snore?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never
- Don't know

16. Has your snoring ever bothered other people?

- Yes
- No
- Don't know

17. Has anyone noticed that you quit breathing during your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never
- Don't know

18. How often do you feel tired or fatigued after your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never
- Don't know

19. During your waking time, do you feel tired, fatigued or not up to par?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never
- Don't know

20. Have you ever nodded off or fallen asleep while driving a vehicle?

- Yes
- No
- Don't drive

21. If yes 20, how often this occur?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never
- Don't know

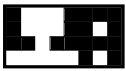
22. Do you have high blood pressure?

- Yes
- No
- Don't know

23. Do you have problems with sleeping through the night? Yes No

24. Do you take an afternoon nap or some kind of other nap during the day? Yes No

25. How many minutes per day on average? Minutes



Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

26. Sitting and reading.

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

27. Watching TV.

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

28. Sitting inactive in a public place (e.g. a theater/ meeting).

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

29. As a passenger in a car for an hour without a break.

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

30. Lying down to rest in the afternoon when circumstances permit.

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

31. Sitting and talking to someone.

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

32. Sitting quietly after a lunch without alcohol.

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

33. In a car, while stopped for a few minutes in traffic.

- Would never doze Slight chance of dozing Moderate chance of dozing High chance of dozing

Diseases diagnosis

34. Has a doctor or other health care provider ever told you that you have asthma? Yes No

[If 'YES', ask questions 34A to 34D. If 'NO' skip to question 35]

34A. How old were you when you had your first attack of asthma? Years

34B. How old were you when you had your most recent attack of asthma? Years

34C. Have you had an attack of asthma in the last 12 months? Yes No

[If 'NO' go to question 34D. If 'YES' answer the following questions]

34C.1 How many attacks of asthma have you had in the last 12 months? Attacks

34C.2 How many attacks of asthma have you had in the last 3 months? Attacks

34C.3 How many times have you woken up because of your asthma in the last 3 months?

- Every night or almost every night Less than twice a month
 More than once a week, but not most nights Not at all
 At least twice a month, but not more than once a week

34D. Do you still have asthma? Yes No

35. Has a doctor or other health care provider ever told you that you have emphysema? Yes No

[If 'YES', ask Question 35A. If "NO", skip to Question 36]

35A. Do you still have emphysema? Yes No

36. Has a doctor or other health care provider ever told you that you have chronic bronchitis? Yes No

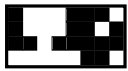
[If "YES", ask Question 36A. If "NO", skip to Question 37]

36A. Do you still have chronic bronchitis? Yes No

37. Has a doctor or other health care provider ever told you that you have COPD? Yes No

[If "YES", ask Question 37A. If "NO", skip to Question CE1]

37A. Do you still have COPD? Yes No



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CE Co-morbidity

1. Have your doctor or other health care provider ever told you that you had any of the following diseases?:

1.1 Myocardial infarction

- No
- Yes, and still suffering from the effects 1.1.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.2 Congestive heart failure

- No
- Yes, and still suffering from the effects 1.2.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.3 Stroke

- No
- Yes, and still suffering from the effects 1.3.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.4 Dementia

- No
- Yes, and still suffering from the effects 1.4.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.5 Rheumatic disorders

- No
- Yes, and still suffering from the effects 1.5.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.6 Arthrosis/ Arthritis

- No
- Yes, and still suffering from the effects 1.6.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.7 Ulcer of stomach/ duodene

- No
- Yes, and still suffering from the effects 1.7.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.8 Diabetes

- No
- Yes, and still suffering from the effects 1.8.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.9 Renal disease

- No
- Yes, and still suffering from the effects 1.9.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

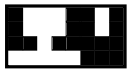
1.10 Cancer

- No
- Yes, and still suffering from the effects 1.10.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.10.2 What kind of cancer?

1.11 High blood pressure

- No
- Yes, and still suffering from the effects 1.11.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years



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1.12 High cholesterol level

- No
- Yes, and still suffering from the effects 1.12.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.13 Disabling backaches

- No
- Yes, and still suffering from the effects 1.13.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.14 Migraine/ headaches

- No
- Yes, and still suffering from the effects 1.14.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.15 Thyroid problems

- No
- Yes, and still suffering from the effects 1.15.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.16 Osteoporosis

- No
- Yes, and still suffering from the effects 1.16.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.17 Persistent pain

- No
- Yes, and still suffering from the effects 1.17.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

1.18 Depression or anxiety

- No
- Yes, and still suffering from the effects 1.18.1 If 'Yes', how old were you when it first occurred?
- Yes, but I no suffering any more form the effects Years

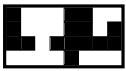
[If 'Yes', to any of the diseases named above ask Questions 2. If 'No', skip to question CF1]

2. Which of the diseases you are suffering is stressing you most?

CF Risk factors and exposures

1. Have you ever smoked cigarettes for as long as a year? Yes No
- ("Yes," means more than 20 packs of cigarettes in a lifetime or more than 1 cigarette each day for a year)
- [If "YES", ask questions 1A through 1D; otherwise, skip to Question 3]
- 1A. How old were you when you first started regular cigarette smoking? Years old
- 1B. If you have stopped smoking, how old were you when you last stopped?
(If the participant has not stopped smoking, record as code '99'.) Years old
- 1C. On average over the entire time that you smoke(d), about how many
cigarettes per day do (did) you smoke? Cigarettes/day
- 1D. On average over the entire time that you smoke(d), do (did) you
primarily smoke manufactured or hand-rolled cigarettes? Manufactured Hand rolled

[If the participant currently smokes cigarettes (question 1B is '99'), then ask questions 2A and 2B. otherwise, skip to Question 3]



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2A. In the last year, how many times have you quit smoking for at least 24 hours?

2B. Are you seriously thinking of quitting smoking?

- Yes, the next 30 days
- Yes, within the next 6 months
- No, not thinking of quitting

3. Have you ever smoked a pipe or cigar? Yes No

[If 'YES', ask question 3A. If 'NO' to question 3 but "YES" to question 1, proceed to question 4. If "NO" to questions 1 and 3, proceed to question 6]

3A. Do you now smoke a pipe or cigar? Yes No

[If the participant has never smoked (answered 'NO' to both questions 1 and 3), then skip to question 6.]

4. Has a doctor or other health care provider ever advised you to quit smoking? Yes No

[If 'YES', ask questions 4A and 4B. If 'NO', skip directly to Question 5]

4A. Have you received medical advice to stop smoking within the past 12 months? Yes No

4B. Have you used any medication (prescription or non-prescription), including a nicotine patch, to help you stop smoking? Yes No

[If "YES", ask question 4B1, then ask question 5. If "NO", skip directly to question 5]

4B1. What kind of medication did you take to help you stop smoking?

- Nicotine replacement
- Buproprium
- Tofranil
- Other

5. Have you used or done anything by yourself to help you stop smoking? Yes No

[If "YES", ask questions 5A. If "NO", skip directly to Question 6]

5A. What did you do? Medication Hypnosis Acupuncture Biofeedback Other

6. Has anyone living in your home (besides yourself) regularly smoked a cigarette, pipe or cigar in your home during the past 12 months? Yes No

Occupational and Environment Exposure

7. Have you ever worked for a year or more in a dusty job? Yes No

[If "YES", ask question 7A]

7A. For how many years have you worked in dusty jobs?

8. Have you ever worked for a year or more exposed to fumes gases or chemicals? Yes No

[If "YES", ask question 8A]

8A. For how many years have you worked under this exposures?

9. How much were you annoyed by outdoor air pollution (from traffic, industry, etc) in your home if you kept windows open?

Inbtolerable annoyance 0 1 2 3 4 5 6 7 8 9 10 Doesn't annoy at all

10. How often do cars pass your house?

- Constantly
- Frequently
- Seldom
- Never

11. How often do heavy vehicles (e.g. trucks/buses) pass your house?

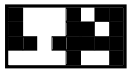
- Constantly
- Frequently
- Seldom
- Never

12. Do (or did) you have pets with fur or feathers in the home? Yes No

[If "YES", ask question 12A, if "NO", skip directly to question CG1]

12A. Indicate which pets do you have at home at the moment?

- Cat
- Dog
- Bird
- Rabbit
- Others
- Not any



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CG Utilization of health services and clinical management

1. Has a doctor or other health care provider ever had you blow into a machine or device in order to measure your lungs (i.e., a spirometer or peakflow meter)? Yes No

[If "YES", ask question 1A. If "NO", skip to question 2]

1A. Where did you blow into this machine?

In a primary care centre In a hospital In a private specialist clinic

1B. Have you used such a machine in the past 12 months? Yes No

2. Have you visited a hospital casualty department or emergency room in the last 12 months? Yes No

[If "YES", ask questions 2A, 2B, 2C. If "NO", skip to question 3]

2A. How many times in the last 12 months?

2B. How many of this visits were due to asthma, shortness of breath chronic bronchitis or COPD)?

2C. How many of this visits were due to a non respiratory problems?

3. Have you spent a night in hospital in the last 12 months? Yes No

[If "YES", ask question 3A, 3B, 3C,3D. If "NO", skip to question 4]

3A Could you tell us the hospital name?

3B How many nights did you stay in a hospital in the last 12 month?

3C. How many of these nights you stayed in a hospital during the last 12 months were due to asthma, shortness of breath chronic bronchitis or COPD)?

Could you tell us how many of these nights you spent on each of the following types of ward in the last 12 months (multiple response)?

3D.1 General

3D.2 Chest Medicine

3D.3 Rehabilitation

3D.4 Intensive care unit

3D.5 Others

4. Have you been seen by a general pratitioner because of breathing problems or shortness of breath in the last 12 months? Yes No

[If "YES", ask question 4A1 to 4A4. If "NO", skip to question 5]

How many times have you been seen by your general practitioner because of breathing problems or shortness of breath in each of these locations over the last 12 months (multiple response)?

4A.1 At home (excluding emergency visits)

4A.2 In his surgery

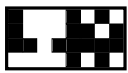
4A.3 At home in an emergency

4A.4 At another location

5. Have you seen a specialist (chest physician, allergy specialist, internal medicine specialist, ENT) because of your breathing problems or shortness of breath in the last 12 months? Yes No

[If "YES", ask question 5A. If "NO", skip to question 6]

5A. How many times?



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6. Are you given regular appointments to be seen by a doctor or nurse for your breathing problems? Yes No

[If "YES", ask question 6A, 6B, 6C. If "NO", skip to question 7]

6A. Are you given regular appointments with a hospital doctor? Yes No

6B. Are you given regular appointments with your general practitioner? Yes No

6C. Are you given regular appointments with a nurse? Yes No

7. How many times have you visited the following because of your breathing problems or shortness of breath in the last 12 months (multiple response)?

7A. Nurse

7B. Physiotherapist

7C. Practitioner of "alternative" medicine

8. Have you had any clinical or laboratory tests because of your breathing problems in the last 12 months? Yes No

9. Do you have a written plan on how to take medicines and activities recommended? Yes No

10. In the past 12 months did you get a flu shot? Yes No

11. During the past 12 months, did health problems prevent you from participating in one or more of your usual activities? Yes No

[If "YES", ask question 11A and 11B, if "NO", skip to question CH1]

11A. During the past 12 months, how many total days did you not participate in your usual activities due to your health problems?

11B. During the past 12 months, how many total days did you not participate in your usual activities due to your breathing problems or shortness of breath?

CH Prescribed medication

1A. Medications name

1B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

1C. How many complete tablets/dose do you take per day? .

1D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 1E and 1F]

1E. When you are taking the medication, how many days a week do you take it?

1F. When you are taking the medication, how many months in the past 12 months you have taken it?

2A. Medications name

2B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

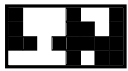
2C. How many complete tablets/dose do you take per day? .

2D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 2E and 2F]

2E. When you are taking the medication, how many days a week do you take it?

2F. When you are taking the medication, how many months in the past 12 months you have taken it?



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3A. Medications name

3B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

3C. How many complete tablets/dose do you take per day? .

3D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 3E and 3F]

3E. When you are taking the medication, how many days a week do you take it? .

3F. When you are taking the medication, how many months in the past 12 months you have taken it?

4A. Medications name

4B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

4C. How many complete tablets/dose do you take per day? .

4D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 4E and 4F]

4E. When you are taking the medication, how many days a week do you take it?

4F. When you are taking the medication, how many months in the past 12 months you have taken it?

5A. Medications name

5B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

5C. How many complete tablets/dose do you take per day? .

5D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 5E and 5F]

5E. When you are taking the medication, how many days a week do you take it?

5F. When you are taking the medication, how many months in the past 12 months you have taken it?

6A. Medications name

6B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

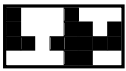
6C. How many complete tablets/dose do you take per day? .

6D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 6E and 6F]

6E. When you are taking the medication, how many days a week do you take it?

6F. When you are taking the medication, how many months in the past 12 months you have taken it?



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7A. Medications name

7B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

7C. How many complete tablets/dose do you take per day? .

7D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 7E and 7F]

7E. When you are taking the medication, how many days a week do you take it?

7F. When you are taking the medication, how many months in the past 12 months you have taken it?

8A. Medications name

8B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

8C. How many complete tablets/dose do you take per day? .

8D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 8E and 8F]

8E. When you are taking the medication, how many days a week do you take it?

8F. When you are taking the medication, how many months in the past 12 months you have taken it?

9A. Medications name

9B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

9C. How many complete tablets/dose do you take per day? .

9D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 9E and 9F]

9E. When you are taking the medication, how many days a week do you take it?

9F. When you are taking the medication, how many months in the past 12 months you have taken it?

10A. Medications name

10B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

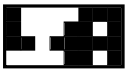
10C. How many complete tablets/dose do you take per day? .

10D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 10E and 10F]

10E. When you are taking the medication, how many days a week do you take it?

10F. When you are taking the medication, how many months in the past 12 months you have taken it?



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11A. Medications name

11B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

11C. How many complete tablets/dose do you take per day? .

11D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 11E and 11F]

11E. When you are taking the medication, how many days a week do you take it?

11F. When you are taking the medication, how many months in the past 12 months you have taken it?

12A. Medications name

12B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

12C. How many complete tablets/dose do you take per day? .

12D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 12E and 12F]

12E. When you are taking the medication, how many days a week do you take it?

12F. When you are taking the medication, how many months in the past 12 months you have taken it?

13A. Medications name

13B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

13C. How many complete tablets/dose do you take per day? .

13D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 13E and 13F]

13E. When you are taking the medication, how many days a week do you take it?

13F. When you are taking the medication, how many months in the past 12 months you have taken it?

14A. Medications name

14B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

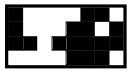
14C. How many complete tablets/dose do you take per day? .

14D. Is the medicine taken most days, or just when you have symptoms, or both?
 Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 14E and 14F]

14E. When you are taking the medication, how many days a week do you take it?

14F. When you are taking the medication, how many months in the past 12 months you have taken it?



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15A. Medications name

15B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

15C. How many complete tablets/dose do you take per day? .

15D. Is the medicine taken most days, or just when you have symptoms, or both?

Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 15E and 15F]

15E. When you are taking the medication, how many days a week do you take it?

15F. When you are taking the medication, how many months in the past 12 months you have taken it?

16A. Medications name

16B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

16C. How many complete tablets/dose do you take per day? .

16D. Is the medicine taken most days, or just when you have symptoms, or both?

Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 16E and 16F]

16E. When you are taking the medication, how many days a week do you take it?

16F. When you are taking the medication, how many months in the past 12 months you have taken it?

17A. Medications name

17B. Formulation Pills Inhaler Nebulizer Liquid Suppository Injection Other

17C. How many complete tablets/dose do you take per day? .

17D. Is the medicine taken most days, or just when you have symptoms, or both?

Most days Symptoms Both

[If 'Symptoms', go to next medication. If 'Most days or both' ask question 17E and 17F]

17E. When you are taking the medication, how many days a week do you take it?

17F. When you are taking the medication, how many months in the past 12 months you have taken it?

18. In the past 4 weeks, have you taken regularly any vitamins or mineral pills?

19. In the past 4 weeks, have you taken regularly any dietary supplements?

18.1

19.1

18.2

19.2

18.3

19.3

18.4

19.4

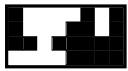
18.5

19.5

18.6

19.6

20. Who answered the questionnaire? Participant alone
 Participant with relatives together (little help)
 Participant with relatives together (much help)
 Almost only the relatives



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CI - Blood pressure

1. The blood pressure is going to be measured? Yes No
2. Posture of the subject during measurement? Sitting Supine
3. Arm used for the measurement? Left Right
[If 'Left' arm used answer question 4]
4. Reasons for using the left arm? Amputation of right arm
 Cast in right arm
 Open wounds/sores on right arm
 Rash on the right arm
 Arteriovenous shunt
 Other
- | Results of blood pressure measurements: | Pulse rate: |
|---|---|
| 5.1 - Systolic 1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 5.2 - Diastolic 1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 5.4 - Systolic 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 5.5 - Diastolic 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 5.7 - Systolic 3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | 5.8 - Diastolic 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| | 5.3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| | 5.6 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| | 5.9 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
6. Have the blood pressure measurements been done? Yes No
7. If 'No', why they were not performed?
 Refusal Technical problem Other, specify: 7.1

CJ - Pulse-oximetry

1. The pulse-oximetry test is going to be performed? Yes No
2. Value %
3. Pulse rate:
4. Has the pulse-oximetry test been completed? Yes No
5. If the pulse oximetry test was NOT completed or initiated, why?
 Refusal Technical problem Other, specify: 5.1

CK - Weight measurement

1. The weight measurement is going to be performed? Yes No
2. Weight .
3. Has the weight measurement been performed? Yes No
4. If 'No', why was not performed?
 Wheelchair bound Difficult to stand Bed driven Other, specify: 4.1

CL - Height measurement

1. The height measurement is going to be performed? Yes No
2. Height (cm)
3. Has the height measurement been performed? Yes No
4. If 'No', why was not performed?
 Wheelchair bound Difficult to stand Bed driven Other, specify: 4.1



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CM - Pre-Bronchodilator Spirometry

Safety Questions

1. In the past three months have you had any surgery on your chest or abdomen? Yes No
 2. Have you had a heart attack within the past three months? Yes No
 3. Do you have a detached retina or have you had eye surgery within the past three months? Yes No
 4. Have you been hospitalized for any other heart problem within the past month? Yes No
 5. Does the participant have a resting pulse of greater than 120 beats per minute? Yes No
 6. Are you currently taking medication for tuberculosis? Yes No
 7. Is there some other reason why this participant should not perform the spirometry maneuver? Yes No
- 7.1 If question 7 'Yes', specify:

If the answer to any of Questions 1 through 7 is "Yes", do NOT proceed with the spirometry test.
If the answer is 'No' continue and ask questions 8 and 9.

8. Have you had a respiratory infection (cold) in the last three weeks? Yes No
9. Have you taken any medications for breathing in the last six hours? Yes No

If 'Yes', record name/type of medication(s) used (multiple response):

- | | | | |
|---|--|-------------------------------|--|
| 9.1 Short-acting B2 agonist (Albuterol/albutamol) | <input type="radio"/> Yes <input type="radio"/> No | 9.2 6 hours prior to test | <input type="radio"/> Yes <input type="radio"/> No |
| 9.3 Anticholinergic inhaler (Atrovent/Ipratropium) | <input type="radio"/> Yes <input type="radio"/> No | 9.4 6 hours prior to test | <input type="radio"/> Yes <input type="radio"/> No |
| 9.5 Oral B2 agonist (Albuterol) | <input type="radio"/> Yes <input type="radio"/> No | 9.6 12 hours prior to test | <input type="radio"/> Yes <input type="radio"/> No |
| 9.7 Oral theophylline (Theodur) | <input type="radio"/> Yes <input type="radio"/> No | 9.8 12-24 hours prior to test | <input type="radio"/> Yes <input type="radio"/> No |
| 9.9 Long acting B2 agonist (Serevent/Symbicort) | <input type="radio"/> Yes <input type="radio"/> No | 9.10 12 hours prior to test | <input type="radio"/> Yes <input type="radio"/> No |
| 9.11 Long acting anticholinergic (Spiriva/Tiotropium) | <input type="radio"/> Yes <input type="radio"/> No | 9.12 24 hours prior to test | <input type="radio"/> Yes <input type="radio"/> No |

10. The pre-bronchodilator spirometry test is going to be performed? Yes No
11. Acceptable pre-bronchodilator spirometry test completed? Yes No

If 'No' answer question 11A

11A. Unable to obtain satisfactory spirometry (check one)

- The participant did not understand instructions
- The participant was medically excluded
- The participant was unable to physically cooperate
- The participant refused

Spirometry Results Pre-bronchodilator (Transmitted from NDD spirometer q12 - q20)

FVC <input type="text"/>	PEF <input type="text"/>	FEV1/ FVC <input type="text"/>
FEV1 <input type="text"/>	FV <input type="text"/>	FEV6/ FVC <input type="text"/>
FEV6 <input type="text"/>	VT <input type="text"/>	Q1 <input type="text"/>



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CN - Post-Bronchodilator Spirometry

Post-bronchodilator test

1. Has the participant taken the bronchodilator drug? Yes No

If 'No' answer question 21A. If 'Yes' answer question 22

1A. Why not? Do not want to take drugs Refuse to continue the test Others

2. The post-bronchodilator test is going to be performed? Yes No

3. Acceptable post-bronchodilator spirometry test completed? Yes No

If 'No' answer question 23A

3A. Unable to obtain satisfactory spirometry (check one)

- The participant was unable to understand instructions
- The participant has been excluded for medical reasons
- The participant was unable to physically cooperate
- The participant refused

Spirometry Results Post-bronchodilator (Transmitted from NDD spirometer q4-q12)

FVC . PEF . FEV1/ FVC .

FEV1 . FV FEV6/ FVC .

FEV6 . VT Q1

13. Were any adverse events related to the spirometry maneuver observed by the evaluator?

If 'Yes', please briefly describe event:

14. If the participant had a condition that would affect the result of their spirometry test (e.g., kyphosis, dentures, missing limbs, etc.) note that condition here.

15. Fieldworker Number

CO - Measurements and assessments results

1. The participant want to receive the results in order to be able to comment them with the GP? Si No

NOTE: The results will not be immediately available and can take some time before the coordinating centre can send them to each participant.

We have now finalized and completed the questionnaires and measurements. However, in a later stage we can be interested in contacting you again one or two years later to assess again some aspects of your health of interest for this study. This means that we may ask you to complete a questionnaire and do some measurements again.

2. Accepta a participar en el seguiment del nostre estudi? Si No

3. Podria facilitar-nos 1 o 2 numeros de telèfons per a poder contactar amb vosté?

Telefon number

Mobile phone