



Institution _____ Institution No. _____

Case No. _____

If this is a revised or corrected form, please box.

Pt Questionnaire: Military History

1. Indicate your current military status:

Active Duty Military

Retired Military

Veteran

Family member of Active Duty / Veteran

2. Have you ever been deployed? No
 Yes

3. If you have been deployed, please provide the location of deployment(s)

Deployment Country

Total Length of Deployment

1. _____	_____ weeks	_____ months	_____ years
2. _____	_____ weeks	_____ months	_____ years
3. _____	_____ weeks	_____ months	_____ years
4. _____	_____ weeks	_____ months	_____ years
5. _____	_____ weeks	_____ months	_____ years
6. _____	_____ weeks	_____ months	_____ years
7. _____	_____ weeks	_____ months	_____ years
8. _____	_____ weeks	_____ months	_____ years
9. _____	_____ weeks	_____ months	_____ years
10. _____	_____ weeks	_____ months	_____ years
11. _____	_____ weeks	_____ months	_____ years
12. _____	_____ weeks	_____ months	_____ years
13. _____	_____ weeks	_____ months	_____ years
14. _____	_____ weeks	_____ months	_____ years
15. _____	_____ weeks	_____ months	_____ years

If you've been deployed more than 15 times, please list the additional deployment countries on the back of this page



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Pt Questionnaire: Occupational History

4. Please check the occupations that you have ever worked

#	Occupation	Total Number of Months/Years Worked		Did you wear a respirator?		
		Months	Years	O No	O Yes	O Unknown
1.	<input type="checkbox"/> Airline Industry (pilot, flight attendant, and/or flight crew)	Months	Years	O No	O Yes	O Unknown
2.	<input type="checkbox"/> Baking	Months	Years	O No	O Yes	O Unknown
3.	<input type="checkbox"/> Butchering/Meat Packing	Months	Years	O No	O Yes	O Unknown
4.	<input type="checkbox"/> Chemical or plastics manufacturing	Months	Years	O No	O Yes	O Unknown
5.	<input type="checkbox"/> Coal Mining	Months	Years	O No	O Yes	O Unknown
6.	<input type="checkbox"/> Cotton or jute processing	Months	Years	O No	O Yes	O Unknown
7.	<input type="checkbox"/> Duty involving exposure to ionizing radiation	Months	Years	O No	O Yes	O Unknown
8.	<input type="checkbox"/> Farming	Months	Years	O No	O Yes	O Unknown
9.	<input type="checkbox"/> Fire Fighting	Months	Years	O No	O Yes	O Unknown
10.	<input type="checkbox"/> Flour, feed, or grain milling	Months	Years	O No	O Yes	O Unknown
11.	<input type="checkbox"/> Foundry or steel milling	Months	Years	O No	O Yes	O Unknown
12.	<input type="checkbox"/> Hard Rock Mining	Months	Years	O No	O Yes	O Unknown
13.	<input type="checkbox"/> Painting	Months	Years	O No	O Yes	O Unknown
14.	<input type="checkbox"/> Sandblasting	Months	Years	O No	O Yes	O Unknown
15.	<input type="checkbox"/> Welding	Months	Years	O No	O Yes	O Unknown
16.	<input type="checkbox"/> Wood working	Months	Years	O No	O Yes	O Unknown
17.	<input type="checkbox"/> Other, specify _____	Months	Years	O No	O Yes	O Unknown
18.	<input type="checkbox"/> None of the above					



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Pt Questionnaire: Occupational Exposure History

5. Please check any occupational exposure that you may have had

#	Occupational Exposure	Total Number of Months/Years Worked		Indicate the amount of exposure you had		Indicate the effect of the exposure	
		Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
1.	<input type="checkbox"/> Asbestos	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
2.	<input type="checkbox"/> Burn Pits	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
3.	<input type="checkbox"/> Chemicals/Acids/Solvents	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
4.	<input type="checkbox"/> Coal Tar/Asphalt	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
5.	<input type="checkbox"/> Diesel Engine Exhaust	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
6.	<input type="checkbox"/> Dyes	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
7.	<input type="checkbox"/> Explosives	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
8.	<input type="checkbox"/> Formaldehyde	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
9.	<input type="checkbox"/> Gasoline Exhaust	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
10.	<input type="checkbox"/> Jet Fuel	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
11.	<input type="checkbox"/> Pesticides/Herbicides (agent orange)	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
12.	<input type="checkbox"/> Radioactive Materials	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
13.	<input type="checkbox"/> Sandstorms	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
14.	<input type="checkbox"/> Smoke	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
15.	<input type="checkbox"/> Textile Fibers/Dust	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
16.	<input type="checkbox"/> Well Water	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
17.	<input type="checkbox"/> Wood Dust	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
18.	<input type="checkbox"/> Other, specify _____	Months	Years	<input type="radio"/> Continuously <input type="radio"/> Occasionally	<input type="radio"/> Regularly	<input type="radio"/> Not noticeable <input type="radio"/> Mild	<input type="radio"/> Moderate <input type="radio"/> Severe
19.	<input type="checkbox"/> None of the above						

PT

ACRIN 4703
Patient Completed Questionnaire

ACRIN PA Study 4703
PLACE LABEL HERE

Institution _____ Institution No. _____

Case No. _____

If this is a revised or corrected form, please box.

Pt Questionnaire: Medical History- Conditions and Illnesses

6. **What is your current weight?** _____ lbs
7. **How tall are you?** _____ feet _____ inches

8. **Please check if your doctor has every told you that you have the listed conditions or illnesses**

#	Condition, Illness	If checked, provide your age when the doctor first told you that you had this illness
1.	<input type="checkbox"/> Asbestosis	
2.	<input type="checkbox"/> Asthma - first diagnosed as a child	
3.	<input type="checkbox"/> Asthma - first diagnosed as an adult	
4.	<input type="checkbox"/> Bronchiectasis	
5.	<input type="checkbox"/> Chronic Bronchitis	
6.	<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	
7.	<input type="checkbox"/> Diabetes	
8.	<input type="checkbox"/> Emphysema	
9.	<input type="checkbox"/> Fibrosis of the Lung	
10.	<input type="checkbox"/> Heart Disease or Heart Attack	
11.	<input type="checkbox"/> High Blood Pressure (Hypertension)	
12.	<input type="checkbox"/> HIV infection	
13.	<input type="checkbox"/> Hodgkins Disease	
14.	<input type="checkbox"/> Pneumonia	
15.	<input type="checkbox"/> Sarcoidosis	
16.	<input type="checkbox"/> Silicosis	
17.	<input type="checkbox"/> Stroke	
18.	<input type="checkbox"/> Tuberculosis (TB)	
19.	<input type="checkbox"/> None of the above	

PT**ACRIN 4703****Patient Completed Questionnaire**ACRIN PA Study 4703
PLACE LABEL HERE

Institution _____ Institution No. _____

Case No. _____

If this is a revised or corrected form, please box. **Pt Questionnaire: Medical History - Cancer****9. Have any of the following blood relatives ever had lung cancer?**

1. Father No Yes Not applicable Unknown
2. Mother No Yes Not applicable Unknown
3. Brother(s), including half brothers No Yes Not applicable Unknown
4. Sister(s), including half sisters No Yes Not applicable Unknown
5. Children (biological) No Yes Not applicable Unknown

10. Please check if your doctor has ever told you that you have any of the cancers the listed below

#	Cancer	If checked, provide your age when the doctor first told you that you had this cancer
1.	<input type="checkbox"/> Bladder Cancer	
2.	<input type="checkbox"/> Breast Cancer	
3.	<input type="checkbox"/> Cervical cancer	
4.	<input type="checkbox"/> Colon-Rectal Cancer	
5.	<input type="checkbox"/> Esophageal Cancer	
6.	<input type="checkbox"/> Kidney Cancer	
7.	<input type="checkbox"/> Larynx Cancer	
8.	<input type="checkbox"/> Lung cancer	
9.	<input type="checkbox"/> Mouth (Oral) Cancer	
10.	<input type="checkbox"/> Nasal Cancer	
11.	<input type="checkbox"/> Pancreatic Cancer	
12.	<input type="checkbox"/> Pharynx Cancer	
13.	<input type="checkbox"/> Stomach (Gastric) Cancer	
14.	<input type="checkbox"/> Thyroid Cancer	
15.	<input type="checkbox"/> Transition Cell Cancer	
16.	<input type="checkbox"/> Other Cancer, Specify _____	
17.	<input type="checkbox"/> Never diagnosed with cancer	



Institution _____ Institution No. _____
 Case No. _____

If this is a revised or corrected form, please box.

Pt Questionnaire: Symptom History: Cough, Shortness of Breath, Exacerbations

Symptom History: Cough

11. Do you usually have a cough? No Yes Unknown

12. Do you usually cough as much as 4-6 times a day, 4 or more days out of the week? No Yes Unknown

13. Do you usually cough at all upon getting up, or first thing in the morning? No Yes Unknown

14. Do you usually cough at all during the rest of the day or night? No Yes Unknown

15. Do you usually cough like this on most days for 3 consecutive months or more during the year? No Yes Unknown

16. For how many years have you had this cough? _____ years

Symptom History: Shortness of Breath

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

18. Do you have to walk slower than people of your age on level ground because of breathlessness? No Yes Unknown

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

20. Are you too breathless to leave the house or do you get breathless upon dressing or undressing? No Yes Unknown

21. For how many years have you experienced shortness of breath? _____ years

Symptom History: Exacerbations

22. Over the past year, how many times did you require treatment with oral steroids and/or antibiotics for a COPD exacerbation (defined as an increase in dyspnea, sputum production or sputum purulence)? _____ times

23. Over the past year, how many of these COPD exacerbations required admission to the hospital? _____ admissions to hospital caused by COPD exacerbations



If this is a revised or corrected form, please box.

Pt Questionnaire: Symptom History: Phlegm and Alcohol History

Symptom History: Phlegm

24. Do you usually bring up phlegm from your chest? No Yes Unknown
 (Count phlegm with the first smoke or on first going out-of doors. Exclude phlegm from the nose. Count swallowed phlegm.) *(If no, skip to Q30)*

24a. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week? No Yes Unknown

25. Do you usually bring up phlegm at all on getting up, or first thing in the morning? No Yes Unknown

26. Do you usually bring up phlegm at all during the rest of the day or at night? No Yes Unknown

If yes to any of the above (Q24, Q24a, Q25, Q26), answer the following two questions; if no to all, skip to the next section.

27. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? No Yes Unknown

28. For how many years have you had trouble with phlegm? _____ years

General Alcohol History

29. Have you ever consumed alcoholic beverages? No Yes Unknown

30. Do you presently drink alcoholic beverages? No Yes Unknown

31. How long has it been since you last had an alcoholic drink (wine, beer, liquor)? Less than 1 year
 1 year to 2 years
 More than 3 years

32. For how many years did you drink alcoholic beverages? _____ years

33. What was the usual number of drinks you had per week? _____ per week
 (one drink means 1 beer or 1 glass of wine or 1 shot of liquor, record 0 if less than 1 drink per week)

34. During the past 24 hours, how many drinks have you had? _____ within last 24 hours

35. Provide your average alcohol consumption
 _____ drinks per week
 _____ drinks in the last year
 _____ drinks in the last 3 years



Institution _____ Institution No. _____
 Case No. _____

If this is a revised or corrected form, please box.

Pt Questionnaire: Smoking History Pt. 1

36. Current smoking status _____
 O Current smoker (one puff in the last month)
 O Former smoker [not smoking for ≥ 1 month(not even a puff)]
 O Never smoked - skip to next section

37. Please indicate your current smoking habit _____
 O Never smoked
 O Former smoker [not smoking for ≥ 1 month(not even a puff)]
 O Occasional smoker (≤ 6 cigarettes per week)
 O Regular smoker (≥ 7 cigarettes per week)

38. Average # cigarettes per day _____ per day

39. Number of years smoking _____ years

40. How old were you the first time you EVER smoked even a puff of a cigarette? _____ years old

41. When you first started smoking a few cigarettes (between 2-10), how much did you feel dizzy?
 O Not at all
 O A slight amount
 O A moderate amount
 O An intense amount
 O Don't know

42. When you first started smoking a few cigarettes (between 2-10), how much did you feel a pleasureable rush or buzz?
 O Not at all
 O A slight amount
 O A moderate amount
 O An intense amount
 O Don't know

43. How old were you when you began smoking daily (at least one cigarette per day or more)? _____ years old

For the next questions, think about the time period when you smoked most

44. Think about the time you smoked the most. How many cigarettes did you smoke per day? _____ cigarettes

45. During the time that you smoked, how many different times in your life did you go without smoking for THREE MONTHS or longer? _____ times

46. Did you find it difficult not to smoke in places where it is forbidden such as in church, at a library, or in a movie theater?
 O No O Yes O Unknown

47. Did you smoke MORE during the first hours after you woke up or during the rest of the day?
 O When I first woke up
 O During the rest of the day



Institution _____ Institution No. _____
Case No. _____

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Pt Questionnaire: Smoking History Pt. 2

48. How soon after you woke up in the morning did you smoke the first cigarette?
 Within 5 minutes
 Within 6 to 14 minutes
 Within 15 to 29 minutes
 Within 30 minutes but less than 1 hour
 Within 1 hour but less than 2 hours
 Within 2 hours but less than 8 hours
 More than 7 hours

49. Did you smoke even if you were so ill that you were in bed most of the day?
 No Yes Unknown

50. When you smoked the most, how often did you inhale?
 None of the time
 Some of the time
 All of the time

51. Which cigarette of the day did you hate to give up the most?
 First one in the morning
 One later in the morning
 One at mid day
 One in the afternoon
 One after work
 One in the evening
 One late at night
 One before bedtime

52. When you smoked the most, what was your usual brand of cigarettes? _____

52a. Was the type: Regular Lights Ultralights

52b. Was the flavor: Regular Menthol

52c. Was the packing: Hard Soft

52d. Were the cigarettes: Filtered Unfiltered

53. Have you ever switched to a low tar, low nicotine or ultralight cigarette?
 No
 Yes
 Unknown

Complete the following 2 questions only if you answered yes to the having switched to a low tar, low nicotine, or ultralight cigarette

54. How old were you when you switched? _____ years old

55. During the time that you were smoking low tar, low nicotine, or ultralight cigarettes, about how many cigarettes did you usually smoke per day?
 _____ per day

56. How many years TOTAL did you smoke low tar, low nicotine, or ultralight cigarettes?
 _____ years old



Institution _____ Institution No. _____
 Case No. _____

If this is a revised or corrected form, please box.

Pt Questionnaire: Secondhand Smoke

The following questions are about exposure to other people's smoking, otherwise known as secondhand smoke

65. Have you EVER lived with someone who smoked in your home? No Yes Unknown
-
66. Do you currently live with someone who smokes in your home? No Yes Unknown
-
67. Not including yourself, how many people smoke(d) in your home? _____ people
-
68. Have you EVER worked in a place where you were exposed to other people's smoking? No Yes Unknown
-
69. Do you currently work in a place where you are exposed to other people's smoking? No Yes Unknown
-
70. Not including yourself, how many people smoke(d) at the place that you worked? _____ other smoker(s)
-
71. Thinking about all of the times that you may have been exposed to other peoples smoking, about how many years in total would you say that you have been exposed to second hand smoke? _____ years

Pt Questionnaire: Demography

72. Indicate the highest grade or level of schooling completed

- 8th grade or less
- 9-11th grade
- High school graduate or high school equivalency
- Post high school training, other than college (for example, Vocational/technical school)
- Associate degree/some college
- Bachelors degree
- Graduate or Professional School
- Other, specify _____
- Unknown / I prefer not to answer

73. Indicate your marital status

- Never married
- Married or living as married
- Widowed
- Separated
- Divorced
- Unknown / I prefer not to answer

74. Indicate household income

- Less than \$8,000 per year
- \$8,000 to 14,999 per year
- \$15,000 to \$24,999 per year
- \$25,000 to \$34,999 per year
- \$35,000 to \$49,999 per year
- \$50,000 to \$64,999 per year
- \$65,000 to \$79,999 per year
- \$80,000 to \$100,000 per year
- >\$100,000 per year
- Unknown/I prefer not to answer

75. Including yourself, how many people are supported by the income listed above?



Institution _____ **Institution No.** _____
Case No. _____

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Pt Questionnaire: Conclusion

76. Did you require any assistance completing this questionnaire No Yes

76a. Please indicate the person who assisted you ACRIN-DECAMP Staff Member
 Family
 Other _____
 Unknown/I prefer not to answer

76b. Please check the extent of assistance

#	Extent of Assistance	Check all that apply
1.	Read items to me	<input type="checkbox"/>
2.	Marked items as I responded	<input type="checkbox"/>
3.	Unknown/I prefer not to answer	<input type="checkbox"/>
4.	Other	<input type="checkbox"/>

77. Specify the method used to complete this questionnaire ACRIN-DECAMP Staff Member
 At my appointment
 By mail
 By telephone
 Unknown/I prefer not to answer
 Other

78. Comments _____

Please check that you have completed every question. At the time you return this questionnaire, please date below.

Date Participant Completed Questionnaire: _____ - _____ - _____ (mm-dd-yyyy)