SPIROMICS
SubPopulations and InteRmediate Outcome Measures In COPD Study

FOLLOW-UP MEDICATION USE

ID NUMBER:									

FORM CODE: **MEF**
VERSION: **1.0 01/31/2025**

Event: _____

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

Instructions: *This form should be completed during the participant's 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.*

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

☐ No$_0$ → **Go to 18**

☐ Yes$_1$

1a) Total number of medications: ☐☐

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: _____N

Note: Questions 15-17 have been removed.

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