

CLINICAL ADVERSE EVENTS

Subject ID: _____
 Subject Initials: _____
 Visit Number: 0 1
 Visit 1 Date: _____ / _____ / _____
month day year

Enter this form when the subject's last visit is completed.

(Clinic Coordinator completed)

If the subject experienced any clinical adverse events (including intercurrent events), complete this log. If no clinical adverse events occurred throughout the entire study, check none, and sign and date this page.

None

Signature: _____
 Date: _____

DESCRIPTION OF ADVERSE EVENT	1. ICD9 CODE	2. DATE STARTED (Top Line)	4. ONGOING at final visit	5. DURATION	6. TYPE	7. SEVERITY	8. SERIOUS	9. LIKELIHOOD OF RELATIONSHIP TO TEST DRUG	10. CHANGE IN STUDY MEDICATIONS	11. OUTCOME <small>(Skip if #4 is checked.)</small>	12. TREATMENT REQUIRED
		3. DATE STOPPED (Bottom Line)		Complete ONLY if duration is less than 24 hours.							
		MONTH / DAY / YEAR		HOUR(S)	1 - INTERMITTENT 2 - CONTINUOUS	1 - MILD 2 - MODERATE 3 - SEVERE	1 - YES * 0 - NO	1 - NONE 2 - UNLIKELY (REMOTE) 3 - POSSIBLE 4 - PROBABLE 5 - HIGHLY PROBABLE	1 - DISCONTINUED 2 - REDUCED 3 - INTERRUPTED, BUT RESUMED AT CURRENT DOSE 4 - UNCHANGED 5 - INCREASED	1 - COMPLETELY RECOVERED 2 - RECOVERED, BUT WITH LASTING EFFECTS * 3 - DEATH	1 - NONE ** 2 - MEDICATION * 3 - HOSPITALIZATION 4 - OTHER
1. EVENT	CAE_01 -----	CAE_02 ----- CAE_03 -----	<input type="checkbox"/> CAE_04	CAE_05 -----	CAE_06	CAE_07	CAE_08	CAE_09	CAE_10	CAE_11	CAE_12
2.	-----	__/__/__ __/__/__	<input type="checkbox"/> ₁	__--							
3.	-----	__/__/__ __/__/__	<input type="checkbox"/> ₁	__--							
4.	-----	__/__/__ __/__/__	<input type="checkbox"/> ₁	__--							
5.	-----	__/__/__ __/__/__	<input type="checkbox"/> ₁	__--							

* Please complete a Serious Adverse Event Reporting Form (SERIOUS).
01/13/97 version 3.2

** Please complete the appropriate Concomitant Medications Log (CMED).

**AIRWATCH™
QUALITY CONTROL**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Current Date: ____/____/____
month day year
 Interviewer ID: _____

(Technician completed)

AIR_01 1. Serial Number of AirWatch™ being tested _____ - _____

AIR_02 2. Serial Number of mouthpiece being tested _____

AIR_03 3. Test date ____/____/____
month day year

AIR_04 4. Is this a new AirWatch™ device being tested? ₁ Yes ₀ No

AIR_04a If **YES**, indicate reason. ₁ "Old" device was recalled ₅ "Old" device was lost
₂ "Old" device failed QC testing ₆ Other
₃ "Old" device had display problems
₄ "Old" device experienced battery failure

	AirWatch™ (L/Min)	Jones FVC (L/Min)
5. Trial 1	AIR_05a	AIR_05b
6. Trial 2	AIR_06a	AIR_06b
7. Trial 3	AIR_07a	AIR_07b
8. Trial 4	AIR_08a	AIR_08b
9. Trial 5	AIR_09a	AIR_09b

Clinic Use Only	
Relative Bias	Rank
$\frac{\text{AirWatch}^{\text{TM}} - \text{Jones FVC}}{\text{Jones FVC}} * 100 \%$	smallest to largest
_____ . _____ %	_____
_____ . _____ %	_____
_____ . _____ %	_____
_____ . _____ %	_____
_____ . _____ %	_____

Clinic Use Only
 Median Relative Bias _____ . _____ % Inter-quartile Range _____ . _____ %
The Median Relative Bias is the third largest value of the 5 measures of relative bias.
The Inter-quartile Range is determined by subtracting the relative bias of rank 2 from the relative bias of rank 4.
When a subject receives a new AirWatch™ or mouthpiece for the first time, the median relative bias must be between -15% and +15%, AND the inter-quartile range must be less than 10%.
When a subject returns to the clinic with a used AirWatch™: (i) subtract the original median relative bias (the median relative bias when the AirWatch™ or mouthpiece was first dispensed) from the current median relative bias, and (ii) subtract the original inter-quartile range (the inter-quartile range when the AirWatch™ or mouthpiece was first dispensed) from the current inter-quartile range. The difference for (i) must be between -5% and +5% and the difference for (ii) must be less than +5% for the AirWatch™ to be reissued to the subject.

AIR_10 10. Did the AirWatch™ pass? ₁ Yes ₀ No

AIR_11 11. If **NO**, is this the third mouthpiece tested with this AirWatch™ at this visit? ₁ Yes ₀ No
 ☞ If **NO**, issue a new mouthpiece and complete another AirWatch™ Quality Control form.
 ☞ If **YES**, issue a new AirWatch™ and mouthpiece and complete another AirWatch™ Quality Control form.

(Technician completed)

BIO_01 1. Serial Number of AirWatch™ being tested _____ - _____

BIO_02 2. Serial Number of mouthpiece being tested _____

	Clinic Use Only	Highest Value
BIO_03 3. Spirometer (L/Min)	_____ . _____	_____
BIO_04 4. AirWatch™ (L/Min)	_____ . _____	_____

Biological Relative Bias

$$\frac{(\text{AirWatch}^{\text{TM}} - \text{Spirometer})}{\text{Spirometer}} * 100\% \quad ______ . ______ \%$$

The Biological Relative Bias must be between -25% and 25%.

BIO_05 5. Did the subject pass the Biological Quality Control testing? ₁ Yes ₀ No

☞ If YES, please continue with Visit 1. Do not complete the rest of this form.
☞ If NO, please check the AirWatch™, reinstruct the subject, and retest. The subject should perform 3 additional AirWatch™ blows which should be compared to the highest spirometry value recorded above (in Question #3).

	Clinic Use Only	Highest Value
BIO_06 6. AirWatch™ (L/Min)	_____ . _____	_____

Biological Relative Bias $\frac{(\text{AirWatch}^{\text{TM}} - \text{Spirometer})}{\text{Spirometer}} * 100\% \quad ______ . ______ \%$

BIO_07 7. Did the subject pass the Biological Quality Control testing? ₁ Yes ₀ No

☞ If YES, please continue with Visit 1.
☞ If NO, and you feel the subject could improve with additional instruction, please complete another BIOQC form. Subjects must pass BIOQC before proceeding with the study.

If the subject cannot pass BIOQC at this visit, please complete the Termination of Study Participation form (TERM).

**CONCOMITANT MEDICATIONS
for
ASTHMA-RELATED DRUGS**

Subject ID: _____

Subject Initials: _____

Visit Number: 0 1

Visit 1 Date: _____ / _____ / _____
month day year

(Clinic Coordinator completed)

At Visit 1: Please list all concomitant medications the subject is taking that are asthma related in the table below.

Indicate the name of the medication, dose, units, frequency, route, and start date. Refer to the Concomitant Medications list (MED) for the codes.

Subsequent visits: Please update the table below at each visit. Indicate any new asthma related medications started and any medications that were stopped since the last visit. If the subject is still taking the medication at the end of the study, please check the "ongoing" box. Check the "None" box if the subject has not taken any asthma related concomitant medications during the entire study.

None

CODE	NAME OF MEDICATION	DOSE	UNITS	FREQUENCY	ROUTE	START DATE (MM/DD/YY)	STOP DATE (MM/DD/YY)	ONGOING AT END OF STUDY
CMED_01	1. CMEDNO	CMED_02		CMED_04		CMED_06	CMED_07	CMED_08
	2.		CMED_03		CMED_05	__/__/__	__/__/__	<input type="checkbox"/> ₁
	3.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	4.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	5.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	6.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	7.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	8.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	9.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	10.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	11.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	12.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	13.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	14.					__/__/__	__/__/__	<input type="checkbox"/> ₁
	15.					__/__/__	__/__/__	<input type="checkbox"/> ₁

Initials: _____
 Date: _____

Please use black ink to complete.

To the subject:							
If your peak flow is below _____ liters/minute, use your Ventolin®(RESCUE) inhaler as instructed in the handout "If Your Asthma Gets Worse." Contact study personnel if your peak flow does not increase to this value after one hour of Rescue use.							
If you have used your Ventolin®(RESCUE) inhaler more than _____ puffs/24 hours for the past 48 hours, contact study personnel.							
	Day 1: _____	Day 2: _____	Day 3: _____	Day 4: _____	Day 5: _____	Day 6: _____	Day 7: _____
Date	dmonth / dday	_____ / _____	_____ / _____	_____ / _____	_____ / _____	_____ / _____	_____ / _____
	<small>month day</small>	<small>month day</small>	<small>month day</small>	<small>month day</small>	<small>month day</small>	<small>month day</small>	<small>month day</small>
MORNING EVALUATION							
1. Number of times that you woke up last night due to asthma	DRY_01	_____	_____	_____	_____	_____	_____
2. Time of AM Peak Flow	DRY_02	____:____	____:____	____:____	____:____	____:____	____:____
3. AM Peak Flow (liters/min)** recorded first thing in the morning	DRY_03	DRY_03R	_____	_____	_____	_____	_____
4. Total number of puffs of Ventolin®(RESCUE) during the night (Do not record preventive puffs.)	DRY_04	_____	_____	_____	_____	_____	_____
Symptoms⁺⁺ during the night.	5. Shortness of Breath	DRY_05					
	6. Chest Tightness	DRY_06					
	7. Wheezing	DRY_07					
	8. Cough	DRY_08					
	9. Phlegm/Mucus	DRY_09					
NIGHT-TIME EVALUATION							
10. Time of PM Peak Flow	DRY_10	____:____	____:____	____:____	____:____	____:____	____:____
11. PM Peak Flow (liters/min)** recorded at bedtime	DRY_11	DRY_11R	_____	_____	_____	_____	_____
12. Total number of puffs of Ventolin®(RESCUE) since you woke (Do not record preventive puffs.)	DRY_12	_____	_____	_____	_____	_____	_____
Symptoms⁺⁺ since you woke.	13. Shortness of Breath	DRY_13					
	14. Chest Tightness	DRY_14					
	15. Wheezing	DRY_15					
	16. Cough	DRY_16					
	17. Phlegm/Mucus	DRY_17					
SCHEDULED MEDICATIONS							
18. Total number of Azmacort® puffs since you woke	DRY_18	_____	_____	_____	_____	_____	_____
** Record the best of three attempts. Circle the value if you have taken any Ventolin® (RESCUE) inhaler medication in the last two hours.		++ Symptom Severity Rating Scale 0 = Absent No symptom 1 = Mild Symptom was minimally troublesome, i.e. not sufficient to interfere with normal daily activity or sleep. 2 = Moderate Symptom was sufficiently troublesome to interfere with normal daily activity or sleep. 3 = Severe Symptom was so severe as to prevent normal activity and/or sleep.					

ELECTROCARDIOGRAM
REPORT

Subject ID: _____
Subject Initials: _____
Visit Number: _____
Visit Date: ____ / ____ / ____
 month day year
Interviewer ID: _____

(Clinic Coordinator completed)

ECG_01

1. Ventricular heart rate _____ beats/min

2. Cardiac cycle measurements

ECG_02A

2a. P - R Interval _____ seconds

ECG_02B

2b. QRS Duration _____ seconds

ECG_02C

2c. Q - T Interval _____ seconds

ECG_03

3. (If Visit 1, do not complete Question # 3.)

Have there been any clinically important changes from Visit 1?

₁ Yes ₀ No

→ If YES, please complete the Clinical Adverse Event form (AECLIN).

ELIGIBILITY CHECKLIST 1

Subject ID: 3
 Subject Initials:
 Visit Number: 0 1
 Visit Date: / /
 month day year
 Interviewer ID:

(Subject Interview completed)

- | | | | | |
|--------|---|--|---|---|
| E1_01 | 1. Did the subject sign the Informed Consent form? | <input type="checkbox"/> ₁ Yes | <input checked="" type="checkbox"/> ₀ No | |
| E1_01A | <i>If YES, record the date the form was signed.</i> | <u> </u> / <u> </u> / <u> </u>
<small> month day year</small> | | |
| E1_02 | 2. Are you between the ages of 12 and 65 years inclusive? | <input type="checkbox"/> ₁ Yes | <input checked="" type="checkbox"/> ₀ No | |
| E1_03 | 3. Do you plan to move more than 75 miles away from this clinic in the next year? | <input checked="" type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | |
| E1_04 | 4. Have you used any smokeless tobacco products (chew, snuff) in the past year? | <input checked="" type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | |
| E1_05 | 5. Have you smoked cigarettes, a pipe, cigars, or any other substance in the past year? | <input checked="" type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | |
| E1_06 | 6. Do you have a smoking history greater than 10 pack-years? | <input checked="" type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | |
| E1_06A | Record history in pack-years. (Enter '00' if none) | <u> </u> <u> </u> | | |
| E1_07 | 7. Have you had a respiratory tract infection in the past 6 weeks? | <input checked="" type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | |
| E1_08 | 8. Have you experienced a significant asthma attack in the past 6 weeks? | <input checked="" type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | |
| E1_09 | 9. Have you experienced a life-threatening asthma attack requiring treatment with intubation and mechanical ventilation in the past 10 years? | <input checked="" type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | |
| E1_10 | 10. Are you potentially able to bear children? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₉ N/A |
| E1_10A | If YES , are you using a birth control method indicated on this reference card? (<i>Show subject the Birth Control Methods reference card.</i>)
→ Please complete the appropriate Concomitant Medications form, if needed. | <input type="checkbox"/> ₁ Yes | <input checked="" type="checkbox"/> ₀ No | |

Initials:
 Date:

- | | | | |
|-------|--|---|---|
| E1_11 | 11. Is the subject eligible? <i>If any of the shaded boxes are filled in, the subject is NOT eligible.</i>
☞ If YES, please continue with Visit 1.
☞ If NO, please complete the Termination of Study Participation form (TERM). | <input type="checkbox"/> ₁ Yes | <input checked="" type="checkbox"/> ₀ No |
|-------|--|---|---|

ELIGIBILITY CHECKLIST 2

Subject ID: 3
 Subject Initials:
 Visit Number: 0 1
 Visit Date: / /
month day year
 Interviewer ID:

(Clinic Coordinator completed)

E2_01

1. Does the subject have current evidence of any of the conditions listed on the Medical Conditions reference card (EXCLMED)?
 If **YES**, describe _____

₁ Yes ₀ No

E2_02

2. Has the subject taken any medications listed on the Exclusionary Drugs reference card (EXCLDRUG) within the specified time periods?
 If **YES**, describe _____

₁ Yes ₀ No

E2_03

3. Is the subject currently taking prescription or over-the-counter medication(s) other than those listed on the Allowed Medications reference card (MEDALLOW)?
 If **YES**, describe _____

₁ Yes ₀ No

E2_04

4. Is the subject currently receiving hyposensitization therapy other than an established maintenance regimen?

₁ Yes ₀ No

E2_05

5. Is the subject currently using intranasal steroids, or does the subject anticipate using intranasal steroids during their participation in the study?

₁ Yes ₀ No

E2_05A

If **YES**, please choose one of the following:

- ₀ The subject agrees to stop use of all intranasal steroids for the duration of the study.
- ₁ The subject agrees to adhere to a course of beclomethasone dipropionate at a dose not to exceed 100 µg in each nostril BID throughout the duration of the study.
 → **Please complete the appropriate Concomitant Medications form.**
- ₂ The subject does not agree to adhere to the criteria regarding intranasal steroid use as outlined in the Manual of Operations.

E2_06

6. Does the subject have an abnormal screening electrocardiogram [ischemic heart disease or arrhythmia; not excluded for occasional (≤ 3/min) atrial or ventricular premature contractions, or clinically insignificant sinus bradycardia]?

₁ Yes ₀ No

E2_07

7. Does the subject have a positive pregnancy test?

₁ Yes ₀ No ₉ N/A

Initials: _____
 Date: _____

E2_08

8. Is the subject eligible? **If any of the shaded boxes are filled in, the subject is NOT eligible.**

₁ Yes ₀ No

- ☞ If YES, please continue with Visit 1.
- ☞ If NO, please complete the Termination of Study Participation form (TERM).

ELIGIBILITY CHECKLIST 3

Subject ID: 3
 Subject Initials:
 Visit Number: 0 1
 Visit Date: / /
month day year
 Interviewer ID:

(Clinic Coordinator completed)

E3_01

1. Is the subject able to use a metered dose inhaler properly? ₁ Yes ₀ No

E3_02

2. Did the subject pass Biological Quality Control (BIOQC) testing at this visit? ₁ Yes ₀ No

E3_03

3. Is the subject eligible? If either of the shaded boxes is filled in, the subject is NOT eligible. ₁ Yes ₀ No

☞ If YES, please continue with this form.

☞ If NO, please complete the Termination of Study Participation form (TERM).

E3_04

4. Is the subject currently taking inhaled corticosteroids? ₁ Yes ₀ No

→ **If NO, complete Section 1.**

→ **If YES, complete Section 2 on the next page.**

Section 1 - Complete for subjects not currently taking inhaled corticosteroids

E3_05

5. Does the subject have a prebronchodilator FEV₁ ≤ 80% of predicted? ₁ Yes ₀ No

E3_06

6. Does the subject have source documentation of ≥ 12% increase in FEV₁ in response to aerosolized albuterol (any spirometry system) in the past 6 months? ₁ Yes ₀ No

E3_07

7. Is the subject eligible? **If either of the shaded boxes in Section 1 is filled in, the subject is NOT eligible.** ₁ Yes ₀ No

☞ If YES, please continue with Visit 1. Do not complete page 2 of this form.

☞ If NO, please complete the Termination of Study Participation form (TERM).

Section 2 - Complete for subjects currently taking inhaled corticosteroids

E3_08

8. Does the subject have a prebronchodilator FEV₁ ≥ 40% of predicted? ₁ Yes ₀ No
 → *If NO, go to Question #10.*

E3_09

9. Does the subject have a prebronchodilator FEV₁ > 80% of predicted? ₁ Yes ₀ No

E3_09A

If **YES**, does the subject have source documentation of PC₂₀ for methacholine ≤ 8 mg/ml (ACRN spirometry system and methodology only) in the past 6 months? ₁ Yes ₀ No
 (Note: If the subject's PC₂₀ for methacholine challenge at this visit ≤ 8 mg/ml, this question should be marked 'Yes.')

E3_09B

If **NO**, does the subject have source documentation of ≥ 12% increase in FEV₁ in response to aerosolized albuterol (any spirometry system) **or** of PC₂₀ for methacholine ≤ 8 mg/ml (ACRN spirometry system and methodology only) in the past 6 months? ₁ Yes ₀ No
 (Note: If the subject's PC₂₀ for methacholine challenge at this visit ≤ 8 mg/ml, this question should be marked 'Yes.')

E3_10

10. Is the subject eligible? ***If any of the shaded boxes in Section 2 are filled in, the subject is NOT eligible.*** ₁ Yes ₀ No
 ☞ If YES, please continue with Visit 1.
 ☞ If NO, please complete the Termination of Study Participation form (TERM).

ELIGIBILITY CHECKLIST 4

Subject ID: 3 _____
 Subject Initials: _____
 Visit Number: 0 4
 Visit Date: _____ / _____ / _____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

E4_01 1. Is the subject's pre-bronchodilator FEV₁ obtained during Visit 4 spirometry less than 55% of predicted? ₁ Yes ₀ No

E4_02 2. Has the subject experienced a significant asthma exacerbation as defined in the Manual of Operations since the first study visit? ₁ Yes ₀ No

E4_03 3. Has the subject used the Azmacort[®] inhaler less than twice a day on more than 12 days during the run-in period? ₁ Yes ₀ No

E4_04 4. On average during the run-in period, has the subject recorded peak flow measurements and symptoms on the symptom diary card fewer than 5 days per week? ₁ Yes ₀ No



E4_05 5. Has the subject used the "as-needed" β-agonist an average of ≥ 16 puffs per 24 hours during the last week of the run-in period (week 6)? ₁ Yes ₀ No

E4_06 6. Is there any new information that makes the subject ineligible according to the eligibility criteria?
 If **YES**, describe _____ ₁ Yes ₀ No

E4_07 7. Does the subject wish to withdraw consent from the study? ₁ Yes ₀ No

E4_08 8. Is there any other reason for which this subject should not be included in the study?
 If **YES**, describe _____ ₁ Yes ₀ No

E4_09 9. Is the subject eligible? ***If any of the shaded boxes are filled in, the subject is NOT eligible.*** ₁ Yes ₀ No

-  If YES, please continue with the randomization process (*next page*).
-  If NO, please complete the Termination of Study Participation form (TERM).

ELIGIBILITY CHECKLIST 4

Subject ID: 3

Visit Number: 0 4

E4_10

10. Is the subject's pre-bronchodilator FEV₁ obtained during Visit 4 spirometry greater than 80% of predicted?

₁ Yes

₀ No

→ If NO, skip to Question #12. The subject should be assigned to the SLIC study.
→ If YES, run the PEF calculator.

E4_11

11. Is the subject's average PEF variability ≤ 20% during the last two weeks of run-in period (weeks 5 and 6)?

₁ Yes

₀ No

→ If YES, the subject should be assigned to the SOCS study.
→ If NO, the subject should be assigned to the SLIC study.

If the subject is eligible to participate in SOCS or SLIC, run the randomization program. If an electronic connection is impossible, call the DCC at (717) 531 - 4262, 8:00 AM - 5:00 PM E.S.T. During the hours 5:00 PM - 9:00 PM E.S.T. call the beeper number and leave a phone number at which you can be contacted.

E4_12

12. In which study is the subject participating?

₁ SOCS

₂ SLIC

Clinic Use Only (SOCS only)
 Information needed for subject randomization:
 Age: _____
 Sex: _____
 Race: _____
 PC₂₀ at visit 4: ____ . _____

E4_13

13. Study drug packet number.

**SPUTUM FLUID
PHASE MEASUREMENTS**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
month day year
 Technician ID: _____

(Technician completed)

				Non-detectable limit	Quantity not sufficient to dilute
1.	ECP	<input type="text" value="ECP"/> _____	mcg/L	<input type="checkbox"/> <input type="text" value="ECP_NON"/>	<input type="checkbox"/> <input type="text" value="ECP_SUFF"/>
2.	Tryptase	<input type="text" value="TRYPTASE"/> _____	mcg/L	<input type="checkbox"/> <input type="text" value="TRY_NON"/>	<input type="checkbox"/> <input type="text" value="TRY_SUFF"/>

LABORATORY TESTS

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: _____ / _____ / _____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

URINE TEST RESULTS

*Run-in: Visit 1 and Visit 4
 SOCS: Visit 10 and Visit 13
 SLIC: Visit 11*

LAB_01

1. Pregnancy test results

Initials: _____
 Date: _____

- ₁ Positive
- ₂ Negative
- ₉ N/A

**→ If pregnancy test results are positive, subject must be terminated from study participation.
 Complete a TERM form and follow study termination procedures.**

BLOOD TEST RESULTS

Electrolyte Analysis

*Run-in: Visit 1
 SOCS: Visit 10
 SLIC: Visit 11*

LAB_02

2. Potassium

_____ mmol/L

LAB_03

3. Sodium

_____ mmol/L

LAB_04

4. Chloride

_____ mmol/L

LAB_05

5. Carbon Dioxide

_____ mmol/L

(Clinic Coordinator completed)

VITAL SIGNS

The subject should sit quietly for five minutes before blood pressure measurements are recorded and maintain this position while all vital signs are taken.

LX_01A

1. Resting blood pressure

____ / ____ mm Hg
systolic diastolic

LX_01B

LX_02

2. Pulse

____ beats/min

LX_03

3. Respiration

____ breaths/min

LX_04

4. Body Temperature

____ . ____ ° F

PULMONARY AUSCULTATION

LX_05

5. Indicate condition of subject. *(Check one box only)*

If applicable, describe sounds:

- ₁ No wheezing
₂ Wheeze on inspiration or expiration
₃ Adventitious sounds other than wheezing

PHYSICAL EXAMINATION

LX_06

6. Does the subject have evidence of oral candidiasis?

- ₁ Yes ₀ No

If YES, please complete the Clinical Adverse Events form (AECLIN).

LONG PHYSICAL EXAM

Subject ID: _____

Visit Number: ____

Please indicate current physical findings by checking the appropriate boxes below, and if ABNORMAL, please describe concisely:

		Not Done	Normal	Abnormal	
<input type="checkbox"/> LX_07	7. Hair and Skin	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_08	8. Lymph nodes	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_09	9. Eyes (excluding corrective lenses)	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_10	10. Ears, Nose, and Throat	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_11	11. Respiratory (excluding asthma)	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_12	12. Cardiovascular	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_13	13. Gastrointestinal	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_14	14. Musculoskeletal	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_15	15. Neurological	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_16	16. Mental Status	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____
<input type="checkbox"/> LX_17	17. Other _____	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀	_____

Physician signature: _____
 Date: ___/___/___
 Time: ___:___

ADVERSE EVENTS (If Visit 1, do NOT complete Question #18.)

LX_18 18. **Ask the subject:** Have you experienced any new medical conditions since the last clinic visit? ₁ Yes ₀ No

If YES, please complete the Clinical Adverse Events form (AECLIN).

If any of the Clinical Adverse Events warrants a laboratory test, report any adverse results on a Laboratory Adverse Events form (AELAB).

MEDICAL HISTORY

Subject ID: 3 _____
Subject Initials: _____
Visit Number: 0_1
Visit Date: _____ / _____ / _____
 month day year
Interviewer ID: _____

(Subject Interview completed)

DEMOGRAPHY

MHX_01

1. What is your date of birth?

_____ / _____ / _____
 month day year

MHX_02

2. What is your ethnic background?

- ₁ American Indian or Alaskan Native
- ₂ Asian or Pacific Islander
- ₃ Black, not of Hispanic Origin
- ₄ White, not of Hispanic Origin
- ₅ Hispanic
- ₆ Other _____

MHX_03

3. What is your sex?

- ₁ Male
- ₂ Female

ASTHMA HISTORY

MHX_04

4. Approximately how old were you when your asthma first appeared? *(Check one box only)*

- ₁ less than 10 years old
- ₂ 10-19 years old
- ₃ 20-29 years old
- ₄ 30-39 years old
- ₅ 40-49 years old
- ₆ 50 years or more
- ₈ unknown

Initials:
Date:

MEDICAL HISTORY

Subject ID: 3 _____

Visit Number: 0 1

MHX_05

5. How many years have you had asthma? (*Check one box only*)

- ₁ less than 1 year
₂ 1-4 years
₃ 5-9 years
₄ 10-14 years
₅ 15 years or more
₈ unknown

MHX_06

6. In what season is your asthma the worst? (*Check one box only*)

- ₁ Winter
₂ Spring
₃ Summer
₄ Fall
₅ Same all year

7. In the last 12 months, how many: (*Enter '00' if none*)

MHX_07A

7a. Asthma episodes have you had that required emergency care or an unscheduled office visit?

___ ___

MHX_07B

7b. Hospitalizations have you had due to asthma?

___ ___

MHX_07C

7c. Courses of oral corticosteroid therapy for asthma (such as prednisone or Medrol) have you taken?

___ ___

MHX_08

8. Have you missed any days of work or school due to asthma in the last 12 months?

- ₁ Yes ₀ No ₉ N/A

MHX_08A

If **YES**, record your best estimate of the number of days missed.

___ ___

9. Have any of your immediate blood relatives been told by a physician that they have asthma? (*Check the 'N/A' box if the subject does not have siblings or children.*)

MHX_09A

9a. Mother

- ₁ Yes ₀ No ₈ Don't Know

MHX_09B

9b. Father

- ₁ Yes ₀ No ₈ Don't Know

MHX_09C

9c. Brothers or Sisters

- ₁ Yes ₀ No ₈ Don't Know ₉ N/A

MHX_09D

9d. Child(ren)

- ₁ Yes ₀ No ₈ Don't Know ₉ N/A

PRIOR ASTHMA TREATMENT

Next, I will read a list of asthma medications. Indicate if you have used the medication. If you have, please indicate to the best of your knowledge, the date last taken.

If Yes, indicate date medication was last taken
month / day / year

- | | | |
|--|--|--|
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_10</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_10X</div> | <p>10. Short acting Inhaled Beta-Agonists (MDI)
(Bronkaid Mist, Duo-Medihaler, Medihaler-Epi, Primatene Mist and others)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_11</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_11X</div> | <p>11. Intermediate acting Inhaled Beta-Agonists (MDI)
(Alupent, Brethaire, Brethine, Bronkometer, Maxair, Metaprel, Proventil, Tornalate, Ventolin and others)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_12</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_12X</div> | <p>12. Long acting Inhaled Beta-Agonists (MDI)
(Serevent)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_13</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_13X</div> | <p>13. Asthma medication via a Nebulizer Machine</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_14</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_14X</div> | <p>14. Intermediate acting Oral Beta-Agonists
(Alupent, Brethine, Bricanyl, Metaprel, Proventil, Ventolin and others)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_15</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_15X</div> | <p>15. Long acting Oral Beta-Agonists
(Repetabs, Volmax)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_16</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_16X</div> | <p>16. Short acting Oral Theophylline
(Aminophylline and others)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_17</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_17X</div> | <p>17. Sustained release Oral Theophylline
(Slo-bid, Theo-Dur, Uniphyl and others)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_18</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_18X</div> | <p>18. Inhaled Anticholinergic
(Atrovent)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_19</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_19X</div> | <p>19. Anti-allergic Medications
(Intal, Nasalcrom, Tilade and others)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |
| <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_20</div> <div style="border: 1px solid black; padding: 2px; width: fit-content;">MHX_20X</div> | <p>20. Oral Steroids
(Prednisone, Medrol and others)</p> | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈ Unknown ___/___/___ |

MEDICAL HISTORY

Subject ID: 3 _____

Visit Number: 0 1

If Yes, indicate date medication was last taken month / day / year

MHX_21

21. Inhaled Steroids (Azmacort, Beclovent, Vanceril, AeroBid, Flovent and others)

_1 Yes _0 No _8 Unknown ___/___/___

MHX_21X

If YES,

MHX_21A

21a. Indicate most recent type.

- _1 beclomethasone dipropionate (1 puff = 42µg) (e.g., Beclovent, Vanceril)
- _2 triamcinolone acetonide (1 puff = 100µg) (e.g., Azmacort)
- _3 flunisolide (1 puff = 250µg) (e.g., AeroBid)
- _4 fluticasone (1 puff = 44, 110, or 220µg) (e.g., Flovent)

MHX_21B

21b. Indicate most recent daily puffs.

___ ___ puffs

MHX_21C

21c. Indicate most recent daily use.

___ ___ ___ µg

MHX_21D

21d. Indicate most recent duration.

- _1 less than 1 month
- _2 1 - 6 months
- _3 greater than 6 months

MHX_22

22. Leukotriene Antagonist / 5LO Inhibitors (Zafirlukast (Accolate), Zileuton)

_1 Yes _0 No _8 Unknown ___/___/___

MHX_22X

MEDICAL HISTORY

Subject ID: 3 _____

Visit Number: 0 1

Have you had any diseases, illnesses, or surgeries related to the following areas?

				If Yes, Comment
MHX_23	23. Skin	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_24	24. Blood, Lymph, or Immune Systems	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_25	25. Eyes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_26	26. Ears, Nose, or Throat	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_27	27. Breasts	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_28	28. Endocrine	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_29	29. Lung	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_30	30. Heart and Blood Vessels	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_31	31. Liver or Pancreas	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_32	32. Kidneys or Urinary Tract System	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_33	33. Reproductive System	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_34	34. Stomach or Intestines	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_35	35. Muscles or Bones	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_36	36. Nervous System	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_37	37. Psychiatric	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____
MHX_38	38. Other _____	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No	_____

**METHACHOLINE CHALLENGE
TESTING**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

Complete this form only if the subject has successfully completed the Spirometry Testing form (SPIRO).

METH_01 1. Has the subject had an acute asthma attack requiring oral steroids (prednisone or a similar drug) in the past 4 weeks? ₁ Yes ₀ No

METH_02 2. Has the subject had any other severe acute illness in the past 4 weeks? ₁ Yes ₀ No

METH_02a If **Yes**, has the subject received permission from the supervising physician to proceed with the methacholine challenge testing? ₁ Yes ₀ No
 Name of physician: _____

METH_03 3. Does the subject have a baseline (pre-diluent) FEV₁ less than 55% of predicted FEV₁? ₁ Yes ₀ No

At visit 1 use the prebronchodilator FEV₁ value from the SPIRO form as the baseline reference.

For visit 4 through final visit:

For SLIC, use the 1 hour post-salmeterol FEV₁ from the SPIRO form as the baseline reference.

For SOCS, use the prebronchodilator FEV₁ value from the SPIRO form as the baseline reference.

METH_04 4. Is there any other reason the subject should not proceed with the methacholine challenge testing? ₁ Yes ₀ No
 If **Yes**, explain _____

METH_05 5. Is the subject eligible to proceed with the diluent (solution #0) pulmonary function testing for the methacholine challenge? ₁ Yes ₀ No

If any of the shaded boxes are filled in, the subject is NOT eligible for the methacholine challenge.

☞ If NO, do NOT complete the rest of this form.

If possible, the baseline pulmonary function testing and the methacholine challenge should be rescheduled within the visit window.

METHACHOLINE CHALLENGE TEST (Technician completed)

Clinic Use Only

At visit 1 use the prebronchodilator FEV₁ value from the SPIRO form as the baseline reference.

For visit 4 through final visit:

For SLIC, use the 1 hour post-salmeterol FEV₁ from the SPIRO form as the baseline reference.

For SOCS, use the prebronchodilator FEV₁ value from the SPIRO form as the baseline reference.

Baseline FEV₁ prior to methacholine challenge

A. FEV₁ _____ . _____ L

B. FEV₁ (% predicted) _____ % predicted

Methacholine Reversal Reference Value Question A x 0.90 = _____ . _____ L

METH_06

6. PC₂₀ _____ . _____ mg/ml

METH_06a

6a. Time methacholine challenge was completed. (based on 24-hour clock) _____

7. Subject's FEV₁ after standard reversal from methacholine challenge

If subject is continuing with sputum induction, standard reversal = 4 puffs albuterol.

If subject is not continuing with sputum induction, standard reversal = 2 puffs albuterol.

METH_07a

7a. FEV₁ _____ . _____ L

METH_07b

7b. FEV₁ (% predicted) _____ % predicted

METH_07c

7c. Time of FEV₁ in Question #7a (based on 24-hour clock) _____

METH_07d

7d. Was the FEV₁ from Question #7a ≥ the methacholine reversal reference value in the gray box above? ₁ Yes ₀ No

→ If YES, stop form and continue with remaining visit procedures.

METHACHOLINE CHALLENGE

Subject ID: _____

Visit Number: _____

- METH_08** 8. Was additional treatment used in the first hour? ₁ Yes ₀ No
→ If NO, skip to Question #10.
→ If YES, please complete the appropriate Concomitant Medications form, if needed.
- METH_08a** 8a. Additional albuterol by MDI ₁ Yes ₀ No
→ If NO, skip to Question #8b.
- METH08a1** 8ai. Number of additional puffs of albuterol administered ₁ two ₂ four ₃ > four
- METH_08b** 8b. Nebulized Beta-agonist ₁ Yes ₀ No
- METH_08c** 8c. Subcutaneous epinephrine ₁ Yes ₀ No
- METH_08d** 8d. Implementation of clinic emergency protocol or algorithm ₁ Yes ₀ No
- METH_08e** 8e. Other _____ ₁ Yes ₀ No
9. Subject's FEV₁ after additional treatment within first hour.
- METH_09a** 9a. FEV₁ _____ . _____ L
- METH_09b** 9b. FEV₁ (% predicted) _____ % predicted
- METH_09c** 9c. Time of FEV₁ in Question #9a (based on 24-hour clock) _____
- METH_09d** 9d. Was the FEV₁ from Question #9a ≥ the methacholine reversal reference value in the gray box on page 2 of this form? ₁ Yes ₀ No
→ If YES, stop form and continue with remaining visit procedures.
- METH_10** 10. Was additional treatment used after one hour? ₁ Yes ₀ No
→ If NO, skip to Question #11.
→ If YES, please complete the appropriate Concomitant Medications form, if needed.
- METH_10a** 10a. Additional albuterol by MDI ₁ Yes ₀ No
→ If NO, skip to Question #10b.
- METH10a1** 10ai. Number of additional puffs of albuterol administered ₁ two ₂ four ₃ > four
- METH_10b** 10b. Nebulized Beta-agonist ₁ Yes ₀ No
- METH_10c** 10c. Subcutaneous epinephrine ₁ Yes ₀ No
- METH_10d** 10d. Implementation of clinic emergency protocol or algorithm ₁ Yes ₀ No
- METH_10e** 10e. Treatment in the emergency room ₁ Yes ₀ No
- METH_10f** 10f. Overnight hospitalization ₁ Yes ₀ No
→ If YES, please complete the Serious Adverse Event form (SERIOUS).
- METH_10g** 10g. Other _____ ₁ Yes ₀ No

METHACHOLINE CHALLENGE

Subject ID: _____

Visit Number: _____

11. Subject's final FEV₁ after methacholine challenge.

METH_11a

11a. FEV₁ _____ . _____ L

METH_11b

11b. FEV₁ (% predicted) _____ % predicted

METH_11c

11c. Time of FEV₁ from Question #11a (*based on 24-hour clock*) _____

METH_11d

11d. Was the FEV₁ from Question #11a \geq the methacholine reversal reference value in the gray box on page 2 of this form?
₁ Yes ₀ No

→ If NO, complete the source documentation box below.

Physician signature: _____ Date: ____ / ____ / ____ Time: ____ : ____

**NITRIC OXIDE
MEASUREMENTS**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
month day year
 Collector ID: _____

Nitric Oxide measurements should be taken after completing the spirometry checklist and prior to performing baseline spirometry.

NO_ANORA ANORA number: _____

(Collector completed)

(Reader completed)

Balloon Id	Time Collected <i>(based on 24-hour clock)</i>	Time Read <i>(based on 24-hour clock)</i>	Measurement (ppb)
NO_BAL1a	NO_BAL1b	NO_BAL1c	NO_BAL1d
NO_BAL2a	NO_BAL2b	NO_BAL2c	NO_BAL2d
NO_BAL3a	NO_BAL3b	NO_BAL3c	NO_BAL3d

NO_DATE Date balloons were read: ____ / ____ / ____
month day year

NO_READ Reader ID: _____

Comments:

**QUALITY OF LIFE
QUESTIONNAIRE**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
month day year
 Interviewer ID: _____

(Subject completed)

Please tell us how much you have been limited by your asthma during the last 2 weeks in each of your 5 most important activities. Refer to the Quality of Life Activities form (QOLACT) for your list of activities. If you have not done the activity in the last 2 weeks, leave the question blank.

HOW LIMITED HAVE YOU BEEN DURING THE LAST 2 WEEKS IN THESE ACTIVITIES?

		Not at all Limited	A Little Limitation	Some Limitation	Moderate Limitation	Very Limited	Extremely Limited	Totally Limited
QOL_01	1. <u>Activity 1</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
QOL_02	2. <u>Activity 2</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
QOL_03	3. <u>Activity 3</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
QOL_04	4. <u>Activity 4</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
QOL_05	5. <u>Activity 5</u>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
QOL_06	6. How much discomfort or distress have you felt over the last 2 weeks as a result of CHEST TIGHTNESS?	None <input type="checkbox"/> ₁	Very Little <input type="checkbox"/> ₂	Some <input type="checkbox"/> ₃	Moderate Amount <input type="checkbox"/> ₄	A Good Deal <input type="checkbox"/> ₅	A Great Deal <input type="checkbox"/> ₆	A Very Great Deal <input type="checkbox"/> ₇

Initials: Date:

QUALITY OF LIFE QUESTIONNAIRE

Subject ID: _____

Visit Number: ____

IN GENERAL, HOW MUCH OF THE TIME DURING THE LAST 2 WEEKS DID YOU:

		None of the Time	Hardly Any of the Time	A Little of the Time	Some of the Time	A Good Bit of the Time	Most of the Time	All of the Time
QOL_07	7. Feel CONCERNED ABOUT HAVING ASTHMA?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_08	8. Feel SHORT OF BREATH as a result of your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_09	9. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO CIGARETTE SMOKE?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_10	10. Experience a WHEEZE in your chest?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_11	11. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF CIGARETTE SMOKE?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
		None	Very Little	Some	Moderate Amount	A Good Deal	A Great Deal	A Very Great Deal
QOL_12	12. How much discomfort or distress have you felt over the last 2 weeks as a result of COUGHING?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

QUALITY OF LIFE QUESTIONNAIRE

Subject ID: _____

Visit Number: ____

IN GENERAL, HOW MUCH OF THE TIME DURING THE LAST 2 WEEKS DID YOU:

		None of the Time	Hardly Any of the Time	A Little of the Time	Some of the Time	A Good Bit of the Time	Most of the Time	All of the Time
QOL_13	13. Feel FRUSTRATED as a result of your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_14	14. Experience a feeling of CHEST HEAVINESS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_15	15. Feel CONCERNED ABOUT THE NEED TO USE MEDICATION for your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_16	16. Feel the need to CLEAR YOUR THROAT?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_17	17. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO DUST?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_18	18. Experience DIFFICULTY BREATHING OUT as a result of your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_19	19. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF DUST?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_20	20. WAKE UP IN THE MORNING WITH ASTHMA SYMPTOMS?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_21	21. Feel AFRAID OF NOT HAVING YOUR ASTHMA MEDICATION AVAILABLE?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_22	22. Feel bothered by HEAVY BREATHING?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_23	23. Experience asthma symptoms as a RESULT OF THE WEATHER OR AIR POLLUTION?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_24	24. Were you WOKEN AT NIGHT by your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_25	25. AVOID OR LIMIT GOING OUTSIDE BECAUSE OF THE WEATHER OR AIR POLLUTION?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

QUALITY OF LIFE QUESTIONNAIRE

Subject ID: _____

Visit Number: ____

IN GENERAL, HOW MUCH OF THE TIME DURING THE LAST 2 WEEKS DID YOU:

		None of the Time	Hardly Any of the Time	A Little of the Time	Some of the Time	A Good Bit of the Time	Most of the Time	All of the Time
QOL_26	26. Experience asthma symptoms as a RESULT OF BEING EXPOSED TO STRONG SMELLS OR PERFUME?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_27	27. Feel AFRAID OF GETTING OUT OF BREATH?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_28	28. Feel you had to AVOID A SITUATION OR ENVIRONMENT BECAUSE OF STRONG SMELLS OR PERFUME?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_29	29. Has your asthma INTERFERED WITH GETTING A GOOD NIGHT'S SLEEP?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
QOL_30	30. Have a feeling of FIGHTING FOR AIR?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
		No Limitation		Very Few Not Done		Several Not Done		Most Not Done
QOL_31	31. Think of the OVERALL RANGE OF ACTIVITIES that you would have liked to have done during the last 2 weeks. How much has your range of activities been limited by your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
		Not at all Limited	A Little Limitation	Some Limitation	Moderate Limitation	Very Limited	Extremely Limited	Totally Limited
QOL_32	32. Overall, among ALL THE ACTIVITIES that you have done during the last 2 weeks, how limited have you been by your asthma?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

**SERIOUS
ADVERSE EVENT
REPORTING FORM**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Current Date: ____/____/____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

This form must be faxed to the DCC at (717) 531-4359 within 72 hours of notification of a serious event. Also fax the Clinical Adverse Events Log (AECLIN), the Concomitant Medications Log (CMED_AS), and any relevant source documents.

SER_01 1. Description of Adverse Event (ICD9 Code) _____
 Describe: _____

SER_02 2. Time interval between taking the study drug (last dose before symptoms) and subsequent onset of symptoms? _____

SER_03 3. Unit of time for above interval
 1 second(s)
 2 minute(s)
 3 hour(s)
 4 day(s)

4. Why was the event serious?

SER_04a 4a. Fatal Event? 1 Yes 0 No

SER_04b 4b. Life-threatening event? 1 Yes 0 No

SER_04c 4c. Inpatient hospitalization required? 1 Yes 0 No

SER_04d 4d. Hospitalization prolonged? 1 Yes 0 No

SER_04e 4e. Disabling or incapacitating? 1 Yes 0 No

SER_04f 4f. Overdose? 1 Yes 0 No

SER_04g 4g. Cancer? 1 Yes 0 No

SER_04h 4h. Congenital anomaly? 1 Yes 0 No

SER_04i 4i. Serious laboratory abnormality with clinical symptoms? 1 Yes 0 No

SER_04j 4j. Other _____ 1 Yes 0 No

5. What, in your opinion, caused the event?

SER_05a 5a. Toxicity of study drug? 1 Yes 0 No

SER_05b 5b. Withdrawal of study drugs? 1 Yes 0 No

SERIOUS ADVERSE EVENT

Subject ID: _____

Visit Number: ____

SER_05c

5c. Concurrent medication?
If **YES**, describe _____

₁ Yes

₀ No

SER_05d

5d. Concurrent disorder?
If **YES**, describe _____

₁ Yes

₀ No

SER_05e

5e. Other event?
If **YES**, describe _____

₁ Yes

₀ No

DO NOT ENTER QUESTIONS # 6 - 7: FOR REPORTING PURPOSES ONLY.

6. If subject died, cause of death: _____

7. Was an autopsy performed?

₁ Yes

₀ No

If YES, attach report or send as soon as possible.

Reporting Investigator:

Name: _____

Address: _____

Signature: _____

Date: ___ / ___ / ___

Comments (discuss any relevant laboratory data or other assessments which help explain the event):

SHORT PHYSICAL EXAM

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

VITAL SIGNS

The subject should sit quietly for five minutes before blood pressure measurements are recorded and maintain this position while all vital signs are taken.

SX_01a
SX_01b

1. Resting blood pressure

_____ / _____ mm Hg
systolic diastolic

SX_02

2. Pulse

_____ beats/min

PULMONARY AUSCULTATION

SX_03

3. Indicate condition of subject. *(Check one box only)*
 If applicable, describe sounds:

- ₁ No wheezing
- ₂ Wheeze on inspiration or expiration
- ₃ Adventitious sounds other than wheezing

SX_04

4. Does the subject have evidence of oral candidiasis?

- ₁ Yes
- ₀ No

If YES, please complete the Clinical Adverse Events form (AECLIN).

Physician/Nurse signature: _____ Date: ____ / ____ / ____ Time: ____ : ____

ADVERSE EVENTS

SX_05

5. *Ask the subject:* Have you experienced any new medical conditions since the last clinic visit?

- ₁ Yes
- ₀ No

If YES, please complete the Clinical Adverse Events form (AECLIN).

If any of the Clinical Adverse Events warrants a laboratory test, report any adverse results of such tests on a Laboratory Adverse Events form (AELAB)

HEALTH STATUS
QUESTIONNAIRE
SF-36

Subject ID: _____
Subject Initials: _____
Visit Number: _____
Visit Date: _____ / _____ / _____
 month day year
Interviewer ID: _____

(Subject completed)

Below are questions about your health in general and questions about your health as it relates specifically to asthma. Please read and answer the questions carefully. If you are not sure about how to answer a question, please give the best answer you can.

SF36_01

1. In general, would you say your health is:

- ₁ Excellent
- ₂ Very Good
- ₃ Good
- ₄ Fair
- ₅ Poor

SF36_02

2. Compared to ONE YEAR AGO, how would you rate your health in general NOW?

- ₁ Much better now than one year ago
- ₂ Somewhat better now than one year ago
- ₃ About the same
- ₄ Somewhat worse now than one year ago
- ₅ Much worse now than one year ago

Initials:
Date:

HEALTH STATUS QUESTIONNAIRE

Subject ID: _____

Visit Number: ____

The following questions are about activities you might do during a typical day. Does YOUR HEALTH now limit you in these activities? If so, how much?

		Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All
SF36_03a	3a. VIGOROUS ACTIVITIES, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03b	3b. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03c	3c. Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03d	3d. Climbing SEVERAL flights of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03e	3e. Climbing ONE flight of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03f	3f. Bending, kneeling, or stooping	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03g	3g. Walking MORE THAN A MILE	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03h	3h. Walking SEVERAL BLOCKS	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03i	3i. Walking ONE BLOCK	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
SF36_03j	3j. Bathing or dressing yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

DURING THE PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

SF36_04a	4a. Cut down on the AMOUNT OF TIME you spent on work or other activities	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
SF36_04b	4b. ACCOMPLISHED LESS than you would like	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
SF36_04c	4c. Were limited in the KIND of work or other activities	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
SF36_04d	4d. Had DIFFICULTY performing the work or other activities <i>(for example, it took extra effort)</i>	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No

HEALTH STATUS QUESTIONNAIRE

Subject ID: _____

Visit Number: ____

DURING THE PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (*such as feeling depressed or anxious*)?

- SF36_05a** 5a. Cut down on the AMOUNT OF TIME you spent on work or other activities ₁ Yes ₀ No
- SF36_05b** 5b. ACCOMPLISHED LESS than you would like ₁ Yes ₀ No
- SF36_05c** 5c. Didn't do work or other activities as CAREFULLY as usual ₁ Yes ₀ No
-
- SF36_06** 6. DURING THE PAST 4 WEEKS, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
- ₁ Not at all
₂ Slightly
₃ Moderately
₄ Quite a bit
₅ Extremely
-
- SF36_07** 7. How much shortness of breath have you had during the PAST 4 WEEKS?
- ₁ None
₂ Very mild
₃ Mild
₄ Moderate
₅ Severe
₆ Very severe
-
- SF36_08** 8. DURING THE PAST 4 WEEKS, how much did pain interfere with your normal work (*including both work outside the home and housework*)?
- ₁ Not at all
₂ A little bit
₃ Moderately
₄ Quite a bit
₅ Extremely

These questions are about how you feel and how things have been with you during the PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the PAST 4 WEEKS...

		All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
SF36_09a	9a. Did you feel full of pep?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09b	9b. Have you been a very nervous person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09c	9c. Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09d	9d. Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09e	9e. Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09f	9f. Have you felt downhearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09g	9g. Did you feel worn out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09h	9h. Have you been a happy person?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
SF36_09i	9i. Did you feel tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

HEALTH STATUS QUESTIONNAIRE

Subject ID: _____

Visit Number: ____

SF36_10

10. DURING THE PAST 4 WEEKS, how much of the time has your physical health or emotional problems interfered with your social activities (*like visiting with friends, relatives, etc.*)?

- ₁ All of the time
- ₂ Most of the time
- ₃ Some of the time
- ₄ A little of the time
- ₅ None of the time

How TRUE or FALSE is each of the following statements for you?

Definitely True Mostly True Don't Know Mostly False Definitely False

SF36_11a

11a. I seem to get sick a little easier than other people.

- ₁ ₂ ₃ ₄ ₅

SF36_11b

11b. I am as healthy as anybody I know.

- ₁ ₂ ₃ ₄ ₅

SF36_11c

11c. I expect my health to get worse.

- ₁ ₂ ₃ ₄ ₅

SF36_11d

11d. My health is excellent.

- ₁ ₂ ₃ ₄ ₅

**SIGNIFICANT ASTHMA
EXACERBATION**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Current Date: ____/____/____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

This form must be completed each time a subject experiences an asthma exacerbation according to the definition below.

1. Did the subject experience an increase in cough, phlegm/mucus, chest tightness, wheezing, or shortness of breath along with any of the following conditions?

SAE_01a

1a. An increase in rescue inhaler use of ≥ 8 puffs per 24 hours over baseline rescue inhaler use for a period of 48 hours?

₁ Yes ₀ No

SAE_01b

1b. Use of rescue inhaler ≥ 16 total puffs per 24 hours for a period of 48 hours?

₁ Yes ₀ No

SAE_01c

1c. PEF which did not increase to $\geq 65\%$ of reference levels after 60 minutes of rescue beta agonist use?

₁ Yes ₀ No

SAE_01d

1d. Symptoms which persisted after 60 minutes of rescue beta-agonist use?

₁ Yes ₀ No

SAE_02

2. Were oral or parenteral corticosteroids given to the subject for his/her asthma exacerbation as a result of rescue intervention or by the opinion of the treating physician?

₁ Yes ₀ No

If any of the shaded boxes are filled in, the subject experienced a significant asthma exacerbation.

If SLIC subject → Please complete this form and continue with the treatment failure packet.

If SOCS subject and the shaded box in Question #2 is checked → Please complete this form and continue with the treatment failure packet.

If the subject does not meet the above criteria as defined in the Manual of Operations, DO NOT COMPLETE THIS FORM.

If the subject has experienced a significant asthma exacerbation but has not yet completed the RUN-IN period, STOP. The subject is ineligible for the study. → Please complete the Termination of Study Participation form (TERM).

SIGNIFICANT ASTHMA EXACERBATION

Subject ID: _____

Visit Number: ____

SAE_03 3. Date of significant asthma exacerbation _____ / _____ / _____
month day year

SAE_04 4. Did the subject seek care for the asthma exacerbation? _1 Yes _0 No
→ If NO, skip to Question #6.

SAE_05a 5. What type of care was sought?
5a. Study Investigator? _1 Yes _0 No

SAE_05a1 If YES, indicate type of contact. _1 Scheduled clinic visit
_2 Unscheduled clinic visit
_3 Phone contact

SAE_05b 5b. Primary Care or Other Physician? _1 Yes _0 No
Name of physician: _____

SAE_05b1 If YES, indicate type of contact. _1 Scheduled clinic visit
_2 Unscheduled clinic visit
_3 Phone contact

SAE_05c 5c. Emergency Room visit? _1 Yes _0 No
Name of hospital: _____

SAE_06 6. Was the subject hospitalized? _1 Yes _0 No
Name of hospital: _____
→ If YES, please complete the Serious Adverse Event Reporting Form (SERIOUS).

SAE_06a If YES,
6a. Duration of hospital stay? _____ days

SAE_06b 6b. Was intubation or ventilation assistance required? _1 Yes _0 No

SAE_07 7. Did the asthma exacerbation require treatment with inhaled, oral, or intravenous glucocorticoids? _1 Yes _0 No
→ If YES, please complete the appropriate Concomitant Medications form, if needed.

SIGNIFICANT ASTHMA EXACERBATION

Subject ID: _____

Visit Number: ____

SAE_08 8. Was the asthma exacerbation treated as outlined in the Manual of Operations?
If **NO**, describe _____

₁ Yes ₀ No

SAE_09 9. Was the significant asthma exacerbation related to the routine pulmonary function testing? *(Check one box only)*

- ₁ Definitely related
- ₂ Probably related
- ₃ Relationship undetermined
- ₄ Probably not related
- ₅ Definitely not related

SAE_10 10. Was the significant asthma exacerbation related to the Methacholine Challenge testing? *(Check one box only)*

- ₁ Definitely related
- ₂ Probably related
- ₃ Relationship undetermined
- ₄ Probably not related
- ₅ Definitely not related

SAE_11 11. Was the significant asthma exacerbation related to the Sputum Induction? *(Check one box only)*

- ₁ Definitely related
- ₂ Probably related
- ₃ Relationship undetermined
- ₄ Probably not related
- ₅ Definitely not related

SAE_12 12. Was the significant asthma exacerbation related to the Bronchoscopy? *(Check one box only)*

- ₁ Definitely related
- ₂ Probably related
- ₃ Relationship undetermined
- ₄ Probably not related
- ₅ Definitely not related

**SIGNIFICANT ASTHMA
EXACERBATION**

Subject ID: _____

Visit Number: ____

(Subject Interview completed)

SAE_13

13. Interval of time since last exacerbation

- ₁ < 1 month
- ₂ 1 - 2 months
- ₃ 3 - 6 months
- ₄ 7 - 12 months
- ₅ > 1 year

SAE_14

14. Over what time period did the subject's asthma symptoms worsen prior to being diagnosed as having a significant asthma exacerbation?

- ₁ 0 - 6 hours
- ₂ 7 - 12 hours
- ₃ 13 - 24 hours
- ₄ 25 - 48 hours
- ₅ > 48 hours

SAE_15

15. Was the asthma exacerbation resolved solely by increasing PRN use of the rescue inhaler?

- ₁ Yes
- ₀ No

SIGNIFICANT ASTHMA EXACERBATION

Subject ID: _____

Visit Number: ____

In the table below, rate each of the following triggering factors with respect to their relationship to the current exacerbation.

- 1 = Definitely related
- 2 = Probably related
- 3 = Relationship undetermined
- 4 = Probably not related
- 5 = Definitely not related

	Triggering factors	Relationship to current asthma exacerbation*
SAE_16	16. Allergen exposure (cat, dog, pollen)	
SAE_17	17. Viral respiratory tract infection (common cold)	
SAE_18	18. Sinus infection	
SAE_19	19. Exercise	
SAE_20	20. Weather conditions	
SAE_21	21. Irritant exposure (smoke, pollution, perfume)	
SAE_22	22. Occupational exposure	
SAE_23	23. Emotional stress	
SAE_24	24. Failure to understand protocol directions	
SAE_25	25. Poor compliance	
SAE_26	26. Health care access problem	
SAE_27	27. Other - Specify:	

* based upon information obtained from the patient and discussed by the clinic coordinator and physician

SAE_28
28. Did allergen exposure occur?
₁ Yes
₀ No

→ If NO, skip to question 29.

SAE_28a
28a. Based upon the subject's allergy skin test, does the time of year of the current exacerbation correlate with these results in your geographic area? (e.g. for the midwest: trees/grass and spring, ragweed and fall, mold and summer/fall, etc.)
₁ Yes
₀ No

SIGNIFICANT ASTHMA EXACERBATION

Subject ID: _____

Visit Number: ____

28b. Based upon the subject's allergy skin test, did the subject have a clinically relevant exposure to any of the following within a 24 hour period prior to the exacerbation?

- | | | | |
|----------|------------------|---|--|
| SAE_28b1 | 28bi. Dog | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| SAE_28b2 | 28bii. Cat | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| SAE_28b3 | 28biii. Pollen | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| SAE_28b4 | 28biv. Mold | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |
| SAE_28b5 | 28bv. Dust mites | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |

SAE_29

29. Did the subject experience any allergic rhinitis symptoms during the week prior to his/her exacerbation?
→ If NO, skip to question 30.

29a. Which of the following symptoms did the subject experience?

- | | | Not
Present | Mild | Moderate | Severe |
|----------|-----------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| SAE_29a1 | 29ai. Watery rhinorrhea | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a2 | 29aia. Purulent rhinorrhea | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a3 | 29aiii. Post nasal drainage | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a4 | 29aiv. Nasal itching | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a5 | 29av. Palatal itching | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a6 | 29avi. Sneezing | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a7 | 29avii. Cough | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a8 | 29aviii. Headache | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a9 | 29aix. Anosmia | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| SAE_29a0 | 29ax. Malaise | <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |

SAE_30

30. Did the subject experience any "cold" symptoms during the week prior to their exacerbation?
→ If NO, skip to question 31.

**SIGNIFICANT ASTHMA
EXACERBATION**

Subject ID: _____

Visit Number: ____

30a. Which of the following "cold" symptoms did the subject experience?

		Not Present	Mild	Moderate	Severe
<input type="checkbox"/> SAE_30a1	30ai. Watery rhinorrhea	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a2	30aii. Purulent rhinorrhea	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a3	30aiii. Post nasal drainage	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a4	30aiv. Headache	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a5	30av. Sore throat	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a6	30avi. Fever	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a7	30avii. Cough	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a8	30aviii. Malaise	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> SAE_30a9	30aix. Muscle aches	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

SAE_31 31. Did sinusitis occur within the last week? ₁ Yes ₀ No
→ If NO, skip to question 32.

31a. If sinusitis occurred within the last week, how was it diagnosed?

<input type="checkbox"/> SAE_31a1	31ai. History and exam	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
<input type="checkbox"/> SAE_31a2	31aii. Sinus radiographs	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
<input type="checkbox"/> SAE_31a3	31aiii. CT scan of sinuses	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No

SAE_31b 31b. Which statement best describes the subject's clinical experience with sinus disease?

₀ NOT a problem
₁ Acute
₂ Subacute
₃ Chronic

SAE_32 32. Did exercise contribute to the current exacerbation? ₁ Yes ₀ No
 Name of activity: _____

SAE_33 33. Did weather conditions contribute to the current exacerbation? ₁ Yes ₀ No
→ If NO, skip to question 34.

**SIGNIFICANT ASTHMA
EXACERBATION**

Subject ID: _____

Visit Number: ____

33a. What weather conditions were felt to be contributory?

- SAE_33a1
- SAE_33a2
- SAE_33a3
- SAE_33a4
- SAE_33a5

33ai. Weather too hot?

₁ Yes ₀ No

33aii. Weather too cold?

₁ Yes ₀ No

33aiii. Weather too dry?

₁ Yes ₀ No

33aiv. Weather too humid?

₁ Yes ₀ No

33av. Change in weather?

₁ Yes ₀ No

Describe change: _____

SAE_34

34. Did irritant exposure contribute to the current exacerbation?

₁ Yes ₀ No

→ If NO, skip to question 35.

34a. Did the subject have relevant exposure to the following irritants?

- SAE_34a1
- SAE_34a2
- SAE_34a3
- SAE_34a4
- SAE_34a5
- SAE_34a6

34ai. Cigarette smoke

₁ Yes ₀ No

34aii. Indoor air pollution

₁ Yes ₀ No

Please specify type of indoor air pollution: _____

34aiii. Outdoor air pollution

₁ Yes ₀ No

Please specify type of outdoor air pollution: _____

34aiv. Perfume/cologne

₁ Yes ₀ No

34av. Aerosols

₁ Yes ₀ No

34avi. Other

₁ Yes ₀ No

Please specify other: _____

SAE_35

35. Did occupational exposure contribute to the current exacerbation?

₁ Yes ₀ No

→ If NO, skip to question 36.

Please specify substance involved: _____

SAE_35a

35a. Was this the first exposure to the above substance?

₁ Yes ₀ No

SAE_35b

35b. Did multiple exposures occur to this substance?

₁ Yes ₀ No

SAE_36

36. Did emotional stress contribute to the current exacerbation?

₁ Yes ₀ No

→ If NO, skip to question 37.

Please describe the stressful situation: _____

SAE_36a

36a. Was this the first time the stressful situation occurred?

₁ Yes ₀ No

SAE_36b

36b. Does this stressful situation occur often?

₁ Yes ₀ No

SIGNIFICANT ASTHMA
EXACERBATION

Subject ID: _____

Visit Number: ____

SAE_37

37. Did failure to understand the protocol directions contribute to the current exacerbation?

→ If NO, skip to question 38.
→ If YES, please describe the failure.

₁ Yes ₀ No

SAE_38

38. Did poor compliance contribute to the current exacerbation?

→ If NO, skip to question 39.
→ If YES, please describe the problem with compliance.

₁ Yes ₀ No

SAE_39

39. Did a problem with access to health care contribute to the current exacerbation?

→ If NO, skip to question 40.
→ If YES, please describe the problem.

₁ Yes ₀ No

SAE_40

40. Are there any other important factors that contributed to the current exacerbation?

→ If YES, please describe.

₁ Yes ₀ No

ALLERGY SKIN TEST RESULTS

Subject ID: 3 _____
 Subject Initials: _____
 Visit Number: 0 1
 Visit Date: _____ / _____ / _____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

SKIN_PST A. Has the subject had a previous skin test using ACRN procedures? ₁ Yes ₀ No

SKIN_PTD If **YES**, date of previous skin test _____ / _____ / _____
month day year

**If the subject had a previous ACRN skin test within three years of the visit date, attach a photocopy of the previous skin test form to this form.
 At the time of data entry, enter section A from this form and then enter the data recorded on the photocopy.**

If any of the medications listed in the skin test section of the ACRN Manual of Operations were taken within the exclusionary periods, reschedule the skin testing procedure.

SKIN_TS B. Skin test site ₁ back ₂ forearm

SKIN_TT Time subject skin **tested** (based on 24-hour clock) _____

SKIN_TE Time skin tests **evaluated** (based on 24-hour clock) _____

ALLERGY SKIN TEST RESULTS

 Subject ID: 3

 Visit Number: 0 1

A reaction is defined as a wheal of at least 3 mm in diameter and an erythema at least 10 mm in diameter. For each allergen, indicate whether there was a reaction. If yes, transfer the tracing of each wheal and record the longest diameter and the diameter at the perpendicular midpoint in mm.

<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_01</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_01a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_01b</div> <p>Diameter _____ mm</p> <p>1. Diluting Fluid</p>	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_08</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_08a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_08b</div> <p>Diameter _____ mm</p> <p>8. Alternaria</p>	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_02</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_02a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_02b</div> <p>Diameter _____ mm</p> <p>2. Tree Fluid</p>	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_09</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_09a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_09b</div> <p>Diameter _____ mm</p> <p>9. Cladosporium</p>
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_03</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_03a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_03b</div> <p>Diameter _____ mm</p> <p>3. Grass Mix</p>	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_10</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_10a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_10b</div> <p>Diameter _____ mm</p> <p>10. Aspergillus</p>	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_04</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_04a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_04b</div> <p>Diameter _____ mm</p> <p>4. Ragweed</p>	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_11</div> <p>Was there a reaction? <input type="checkbox"/>₀ No <input type="checkbox"/>₁ Yes</p> <p>Largest Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_11a</div> <p>Diameter _____ mm</p> <p>Perpendicular Wheal</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px; text-align: center;">SKIN_11b</div> <p>Diameter _____ mm</p> <p>11. D. Farinae</p>

ALLERGY SKIN TEST RESULTS

Subject ID: 3 _____

Visit Number: 0 1

5. Weed Mix	SKIN_05	Was there a reaction? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes Largest Wheal Diameter _____ mm Perpendicular Wheal Diameter _____ mm	12. D. Pteryx	SKIN_12	Was there a reaction? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes Largest Wheal Diameter _____ mm Perpendicular Wheal Diameter _____ mm
6. Dogs	SKIN_06	Was there a reaction? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes Largest Wheal Diameter _____ mm Perpendicular Wheal Diameter _____ mm	13. Cockroach	SKIN_13	Was there a reaction? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes Largest Wheal Diameter _____ mm Perpendicular Wheal Diameter _____ mm
7. Cats	SKIN_07	Was there a reaction? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes Largest Wheal Diameter _____ mm Perpendicular Wheal Diameter _____ mm	14. Histamine	SKIN_14	Was there a reaction? <input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes Largest Wheal Diameter _____ mm Perpendicular Wheal Diameter _____ mm

SPIROMETRY TESTING

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____/____/____
month day year
 Interviewer ID: _____

(Subject Interview completed)

- | | | | |
|----------|--|---|-------------------------------|
| SPIR_01 | 1. <i>(If Visit 1, do not complete Question #1.)</i>
Have you used your Ventolin® (RESCUE) inhaler in the past 6 hours?
<i>If the time is less than 6 hours, pulmonary function testing must be rescheduled.</i> | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_02 | 2. <i>(Visit 5 through Last Visit Only)</i>
<i>(SOCS subjects)</i> Have you used <i>Inhaler 2</i> in the past 48 hours?
<i>(SLIC subjects)</i> Have you used <i>Inhaler 2</i> in the past 12 hours? | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_03 | 3. Have you consumed caffeine in the past 8 hours?
<i>Examples: Caffeinated colas (Pepsi, Coke), Coffee, Mello-Yello, Mountain Dew, Tea</i> | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_04 | 4. Have you used medications with caffeine in the past 8 hours?
<i>Examples: Anacin, Darvon compound, Esgic, Excederin, Fiorinal, Fioricet, No Doz, Norgesic, Vivarin</i> | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_05 | 5. Have you consumed any food containing alcohol or beverages containing alcohol in the past 8 hours? | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_06a | 6a. Have you used fexofenadine (e.g. Allegra) or chlorpheniramine (e.g. Chlor-Trimeton) in the past 48 hours? | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_06b | 6b. Have you used pseudoephedrine (e.g. Sudafed) or oxymetazoline (e.g. Afrin) in the past 48 hours? | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_07 | 7. <i>(For Sputum Induction only)</i> Have you used any cough or cold preparations (e.g. expectorants, decongestants, or antitussives) in the past 48 hours?
<i>→ If Yes, reschedule visit within visit window.</i> | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_08 | 8. Have you had a respiratory tract infection or any other pulmonary infection since the last visit? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_09 | 9. At this time, is your asthma worse because of recent exposure to triggers (for example: cold air, smoke, allergens, or recent exercise)? | <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |
| SPIR_10 | 10. Is there any other reason you should not proceed with the pulmonary function testing?
If YES , explain _____
_____ | <input checked="" type="checkbox"/> 1 Yes | <input type="checkbox"/> 0 No |

SPIROMETRY TESTING

Subject ID: _____

Visit Number: _____

SPIR_11

11. Is the subject eligible to proceed with the pulmonary function testing? *If any of the shaded boxes are filled in, the subject is NOT eligible for testing.*

Yes

No

If YES, please continue.

If NO, do NOT complete page 2 or 3 unless this is a SOCS or SLIC treatment failure visit.

If this is a regular protocol visit, the pulmonary function testing should be rescheduled within the visit window.

SPIR_12

12. Height (*without shoes*)

_____ . _____ cm

Height should be measured at every visit if subject is ≤ 21 years old and only at Visit 1 if subject is > 21 years old.

BASELINE PULMONARY FUNCTION TESTING (*Technician completed*)

SPIR_13

13. Time spirometry started (*based on 24-hour clock*)

The best effort reflects the trial where the sum of FEV₁ and FVC are maximized.

SPIR_14a

14. Results of best effort

FVC _____ L

SPIR_14b

FEV₁ _____ L

SPIR_14c

FEV₁ _____ % predicted

SPIR_14d

PEFR _____ L/S

SPIR_14e

FEF₂₅₋₇₅ _____ L/S

SPIROMETRY TESTING

Subject ID: _____

Visit Number: ____

THIS PAGE IS FOR SLIC VISITS 4 THROUGH 11 AND SLIC TREATMENT FAILURE VISITS ONLY

Visits 5 through 11:

Compare the subject's prebronchodilator FEV_1 in Question #14 to the prebronchodilator value obtained at Visit 4 for possible treatment failure status. See SOCS/SLIC Manual of Operations for details.

SPIR_15a	15. Results of best effort post-salmeterol	FVC	____ . ____ ____ L
SPIR_15b		FEV_1	____ . ____ ____ L
SPIR_15c		FEV_1	____ ____ ____ % predicted
SPIR_15d		PEFR	____ ____ . ____ ____ L/S
SPIR_15e		FEF_{25-75}	____ . ____ ____ L/S

Visits 5 through 11:

Compare the subject's post-salmeterol FEV_1 in Question #15 to the post-salmeterol value obtained at Visit 4 for possible treatment failure status. See SOCS/SLIC Manual of Operations for details.

If the subject did not complete salmeterol reversibility testing please provide an explanation below.

**SPUTUM INDUCTION
LAB
VALUES**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____/____/____
month day year
 Interviewer ID: _____

(Technician completed)

Total and Differential Cell Counts

SLAB_01 1. Total Cell Count _____ . _____ x 10⁵/ml

SLAB_02 2. Squamous Cells _____ . ____ %

The parameters below are calculated following exclusion of squamous cells.

SLAB_03 3. Total Cell Count _____ . _____ x 10⁵/ml

SLAB_04 4. Epithelial Cells _____ . ____ %

SLAB_05 5. Macrophages _____ . ____ %

SLAB_06 6. Neutrophils _____ . ____ %

SLAB_07 7. Eosinophils _____ . ____ %

SLAB_08 8. Lymphocytes _____ . ____ %

SLAB_09 9. Did the subject's sputum sample reveal ≥ 80% squamous cells? 1 Yes 0 No

If the shaded box in Question #9 is filled in, the sputum sample should not be sent for overreading.

SPUTUM INDUCTION

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Visit Date: ____ / ____ / ____
month day year
 Interviewer ID: _____

(Technician completed)

- | | | |
|----------|--|---|
| SPUT_01 | 1. <i>(Visit 5 through Last Visit Only)</i>
At visit 4, was the subject able to continue sputum induction for more than 4 minutes and able to produce a satisfactory induced sputum sample (≥ 1 ml and $< 80\%$ squamous cells)?
→ If NO, stop here. DO NOT proceed with sputum induction.
→ If YES, please continue with this form. | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No |
| SPUT_02 | 2. Did the subject complete the methacholine challenge?
→ If NO, skip to Question #3. | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No |
| SPUT_02a | 2a. Subject's FEV ₁ after all reversal from methacholine challenge | ____ . ____ ____ L |
| SPUT_02b | 2b. Subject's FEV ₁ (% predicted) after all reversal from methacholine challenge | ____ ____ ____ % predicted |
| SPUT_02c | 2c. Was the subject's FEV ₁ from Question #2a \geq the methacholine reversal reference value on page 2 of the METHA form? | <input type="checkbox"/> ₁ Yes <input checked="" type="checkbox"/> ₀ No |
| SPUT_02d | 2d. Is the FEV ₁ from Question #2b $\geq 60\%$ predicted? | <input type="checkbox"/> ₁ Yes <input checked="" type="checkbox"/> ₀ No |

If either of the shaded boxes is filled in, STOP here. DO NOT proceed with sputum induction. If neither of the shaded boxes is filled in, Skip to Question #6 on the next page.

(For subjects who did not complete methacholine challenge)

- | | | |
|---------|---|---|
| SPUT_03 | 3. Subject's FEV ₁ 15 minutes after 4 puffs of albuterol | ____ . ____ ____ L |
| SPUT_04 | 4. Subject's FEV ₁ 15 minutes after 4 puffs of albuterol (% predicted) | ____ ____ ____ % predicted |
| SPUT_05 | 5. Is the subject's post-albuterol FEV ₁ $\geq 60\%$ predicted? | <input type="checkbox"/> ₁ Yes <input checked="" type="checkbox"/> ₀ No |

If the shaded box in Question #5 is filled in, STOP here. DO NOT proceed with sputum induction.

SPUTUM INDUCTION

Subject ID: _____

Visit Number: _____

- SPUT_06** 6. *(If Visit 1, do not complete Question #6.)*
What was the duration of sputum induction the first time it exceeded 4 minutes, not including current visit?
(Duration of sputum induction at current visit should not exceed this.) _____ . _____ minutes
7. Subject's FEV₁ immediately after completion of sputum induction
- SPUT_07a** 7a. FEV₁ _____ . _____ L
- SPUT_07b** 7b. FEV₁ (% predicted) _____ % predicted
- SPUT_07c** 7c. Time of FEV₁ from Question #7a (based on 24-hour clock) _____

Clinic Use Only

% change in FEV₁ after sputum induction $\frac{(\text{Question \#2a or 3} - \text{Question \#7a})}{\text{Question \#2a or 3}} \times 100$: _____ . _____ %

- SPUT_08** 8. Duration of sputum induction at this visit _____ . _____ minutes
- SPUT_09** 9. Volume of sputum sample at this visit _____ . _____ ml

- SPUT_10** 10. Was the subject's sputum sample volume \geq 1 ml at this visit? ₁ Yes ₀ No
- SPUT_11** 11. Did the subject tolerate sputum induction for > 4 minutes at this visit? ₁ Yes ₀ No

- SPUT_12** 12. Is the sample adequate for analysis of squamous cells?
If either of the shaded boxes is filled in, the sputum sample should not be sent for analysis of squamous cell counts. ₁ Yes ₀ No

Complete pages 3 and 4 only if the subject has a fall in FEV₁ (from post-albuterol baseline) of > 20% during or immediately after sputum induction.

Clinic Use Only

Sputum Induction
 Reversal Reference Value (Question #2a or Question #3) x 0.90 = ____ . ____ L

13. Subject's FEV₁ after initial 2 puffs of albuterol following sputum induction

- SPUT_13a** 13a. FEV₁ _____ . _____ L
- SPUT_13b** 13b. FEV₁ (% predicted) _____ % predicted
- SPUT_13c** 13c. Time of FEV₁ from Question #13a (*based on 24-hour clock*) _____
- SPUT_13d** 13d. Was the FEV₁ from Question #13a ≥ the sputum induction reversal reference value in the gray box above? ₁ Yes ₀ No
- If YES, stop form and continue with remaining visit procedures.**

SPUT_14 14. Was additional treatment used in the first hour? ₁ Yes ₀ No

→ If NO, skip to Question #16.
→ If YES, please complete the appropriate Concomitant Medications form, if needed.

- SPUT_14a** 14a. Additional albuterol by MDI ₁ Yes ₀ No
- If NO, skip to Question #14b.**
- SPUT14a1** 14ai. Number of additional puffs of albuterol administered ₁ two ₂ four ₃ > four
- SPUT_14b** 14b. Nebulized Beta-agonist ₁ Yes ₀ No
- SPUT_14c** 14c. Subcutaneous epinephrine ₁ Yes ₀ No
- SPUT_14d** 14d. Implementation of clinic emergency protocol or algorithm ₁ Yes ₀ No
- SPUT_14e** 14e. Other _____ ₁ Yes ₀ No

15. Subject's FEV₁ after additional treatment within the first hour

- SPUT_15a** 15a. FEV₁ _____ . _____ L
- SPUT_15b** 15b. FEV₁ (% predicted) _____ % predicted

SPUTUM INDUCTION

Subject ID: _____

Visit Number: _____

SPUT_15c 15c. Time of FEV₁ from Question #15a (based on 24-hour clock) _____

SPUT_15d 15d. Was the FEV₁ from Question #15a \geq the sputum induction reversal reference value in the gray box on page 3 of this form?
₁ Yes ₀ No
→ If YES, stop form and continue with remaining visit procedures.

SPUT_16 16. Was additional treatment used after one hour?
₁ Yes ₀ No
→ If NO, skip to Question #17.
→ If YES, please complete the appropriate Concomitant Medications form, if needed.

SPUT_16a 16a. Additional albuterol by MDI ₁ Yes ₀ No
→ If NO, skip to Question #16b.

SPUT16a1 16ai. Number of additional puffs of albuterol administered ₁ two ₂ four ₃ > four

SPUT_16b 16b. Nebulized Beta-agonist ₁ Yes ₀ No

SPUT_16c 16c. Subcutaneous epinephrine ₁ Yes ₀ No

SPUT_16d 16d. Implementation of clinic emergency protocol or algorithm ₁ Yes ₀ No

SPUT_16e 16e. Treatment in the emergency room ₁ Yes ₀ No

SPUT_16f 16f. Overnight hospitalization ₁ Yes ₀ No
→ If YES, please complete the Serious Adverse Event form (SERIOUS)

SPUT_16g 16g. Other _____ ₁ Yes ₀ No

17. Subject's final FEV₁ after sputum induction

SPUT_17a 17a. FEV₁ _____ L

SPUT_17b 17b. FEV₁ (% predicted) _____ % predicted

SPUT_17c 17c. Time of FEV₁ from Question #17a (based on 24-hour clock) _____

SPUT_17d 17d. Was the FEV₁ from Question #17a \geq the sputum induction reversal reference value in the gray box on page 3 of this form?
₁ Yes ₀ No
→ If NO, complete the source documentation box below.

Physician signature: _____
Date: ___ / ___ / ___
Time: ___ : ___

**TERMINATION OF STUDY
PARTICIPATION**

Subject ID: _____
 Subject Initials: _____
 Visit Number: _____
 Current Date: ____ / ____ / ____
month day year
 Interviewer ID: _____

(Clinic Coordinator completed)

Please indicate the reason for termination of study participation.

TERM_01

1. (SOCS Visit 13 and SLIC Visit 11 Only)

Has the subject completed the study?

→ **If YES, skip to the SIGNATURES section on page 2.**

₁ Yes ₀ No

TERM_02

2. Is the subject withdrawing from the study due to pregnancy?

₁ Yes ₀ No

Initials:
Date:

TERM_03

3. (Visit 1 through Visit 4 Only)

During the run-in period, has the subject experienced a significant asthma exacerbation as defined in the Manual of Operations?

₁ Yes ₀ No

TERM_04

4. (Visit 1 through Visit 4 Only)

Has the subject been deemed ineligible according to any eligibility criteria **other than** a significant exacerbation?

₁ Yes ₀ No

TERM_05

5. Has the subject withdrawn consent?

₁ Yes ₀ No

TERM_05A

If **YES**, indicate the **primary** reason.

- ₁ no longer interested in participating
- ₂ no longer willing to follow protocol
- ₃ access to clinic is difficult (location, transportation, parking)
- ₄ unable to make visits during clinic hours
- ₅ moving out of the area
- ₆ unable to continue on study due to personal constraints
- ₇ dissatisfied with asthma control
- ₈ unable to continue due to medical condition unrelated to asthma
- ₉ side effects of study medications
- ₁₀ treatment failure
- ₁₁ other _____

TERMINATION OF STUDY
PARTICIPATION

Subject ID: _____

Visit Number: ____

TERM_06

6. Has the subject been lost to follow-up?

₁ Yes ₀ No

TERM_07

7. Did a physician initiate subject termination?

₁ Yes ₀ No

TERM_08

8. Has the subject experienced a serious adverse event
(e.g., hospitalization, death, etc.)?

₁ Yes ₀ No

→ ***If YES, complete the Serious Adverse Event Reporting form (SERIOUS).***

TERM_09

9. ***(SOCS Visits 10 - 13 Only)***

Has the subject been assigned drop-out
status during the single blind run-out period?

₁ Yes ₀ No

SIGNATURES

Please complete the following section regardless of the reason for termination of study participation.

I verify that all information collected on the ACRN SOCS or SLIC data collection forms for this subject is correct to the best of my knowledge and was collected in accordance with the procedures outlined in the ACRN SOCS or SLIC Protocol and Manual of Operations.

TERM_S1

Clinic Coordinator Signature

TERM_DT1

month day year

TERM_S2

Principal Investigator Signature

TERM_DT2

month day year