MEDICAL HISTORY

Subject ID: 2 ___ ___ ___ ___
Subject Initials: ___ ___ ___
Visit Number: 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 race?

- ❑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

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 None

7. In the last 12 months, how many: (*Enter '0' if none*)

MHX_07a 7a. Asthmatic episodes have you had that required emergency care or an office visit? ___ ___

MHX_07b 7b. Hospitalizations have you had due to asthma? ___ ___

MHX_07c 7c. Courses of oral corticosteroid therapy 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 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 is adopted or does not have children, siblings, etc.*)

MHX_09a 9a. Mother ❑1 Yes ❑0 No ❑9 N/A

MHX_09b 9b. Father ❑1 Yes ❑0 No ❑9 N/A

MHX_09c 9c. Brothers or Sisters ❑1 Yes ❑0 No ❑9 N/A

MHX_09d 9d. Child(ren) ❑1 Yes ❑0 No ❑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
MHX_10 MHX_10x	10.	Short acting Inhaled Beta-Agonists (MDI) (**Bronkaid Mist, Duo-Medihaler, Medihaler-Epi, Primatene Mist and others**)	❑1 Yes ❑0 No ❑8 Unknown
MHX_11 MHX_11x	11.	Intermediate acting Inhaled Beta-Agonists (MDI) (**Alupent, Brethaire, Brethine, Bronkometer, Maxair, Metaprel, Proventil, Tornalate, Ventolin and others)**	❑1 Yes ❑0 No ❑8 Unknown
MHX_12 MHX_12x	12.	Long acting Inhaled Beta-Agonists (MDI) (**Serevent**)	❑1 Yes ❑0 No ❑8 Unknown
MHX_13 MHX_13x	13.	Asthma medication via a Nebulizer Machine	❑1 Yes ❑0 No ❑8 Unknown
MHX_14 MHX_14x	14.	Intermediate acting Oral Beta-Agonists (**Alupent, Brethine, Bricanyl, Metaprel, Proventil, Ventolin and others**)	❑1 Yes ❑0 No ❑8 Unknown
MHX_15 MHX_15x	15.	Long acting Oral Beta-Agonists (**Repetabs, Volmax**)	❑1 Yes ❑0 No ❑8 Unknown
MHX_16 MHX_16x	16.	Short acting Oral Theophylline (**Aminophylline and others)**	❑1 Yes ❑0 No ❑8 Unknown
MHX_17 MHX_17x	17.	Sustained release Oral Theophylline (**Slo-bid, Theo-Dur, Uniphyl and others**)	❑1 Yes ❑0 No ❑8 Unknown
MHX_18 MHX_18x	18.	Inhaled Anticholinergic (**Atrovent**)	❑1 Yes ❑0 No ❑8 Unknown
MHX_19 MHX_19x	19.	Anti-allergic Medications (**Intal, Nasalcrom, Gastrocrom, Tilade and others**)	❑1 Yes ❑0 No ❑8 Unknown
MHX_20 MHX_20x	20.	Oral Steroids (**Prednisone, Medrol and others**)	❑1 Yes ❑0 No ❑8 Unknown

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

MHX_21 MHX_21x 21. Anti-Inflammatory Medications (**Azmacort, Beclovent, Vanceril, AeroBid and others**) ❑1 Yes ❑0 No ❑8 Unknown __ __/__ __/__ __

If ***Yes***,

MHX_21a 21a. Indicate most recent type.
- ❑1 beclomethasone diproprionate (1 puff = 42µg)
- ❑2 triamcinolone acetonide (1 puff = 100µg)
- ❑3 fluonisolide (1 puff = 250µg)

MHX_21b 21b. Indicate most recent daily puffs. ___ ___ puffs

Clinic Use Only ___ ___ ___ ___ µg

MHX_21c 21c. Indicate most recent duration.
- ❑1 less than 1 month
- ❑2 1 - 6 months
- ❑3 greater than 6 months

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

				If Yes, Comment
MHX_22	22.	Skin	❑1 Yes ❑0 No	_____
MHX_23	23.	Blood, Lymph, or Immune Systems	❑1 Yes ❑0 No	_____
MHX_24	24.	Eyes	❑1 Yes ❑0 No	_____
MHX_25	25.	Ears, Nose, or Throat	❑1 Yes ❑0 No	_____
MHX_26	26.	Breasts	❑1 Yes ❑0 No	_____
MHX_27	27.	Tissue or Glands	❑1 Yes ❑0 No	_____
MHX_28	28.	Lung disease	❑1 Yes ❑0 No	_____
MHX_29	29.	Heart and Vessel disease	❑1 Yes ❑0 No	_____
MHX_30	30.	Liver or Pancreas	❑1 Yes ❑0 No	_____
MHX_31	31.	Kidneys or Urinary Tract System	❑1 Yes ❑0 No	_____
MHX_32	32.	Reproductive System	❑1 Yes ❑0 No	_____
MHX_33	33.	Stomach or Intestines	❑1 Yes ❑0 No	_____
MHX_34	34.	Muscles or Bones	❑1 Yes ❑0 No	_____
MHX_35	35.	Nervous System	❑1 Yes ❑0 No	_____
MHX_36	36.	Psychiatric	❑1 Yes ❑0 No	_____