ST. GEORGE'S RESPIRATORY QUESTIONNAIRE (SGRQ)

Was this questionnaire completed? _____1=Yes _____0=No

If No, please explain: _____

Before completing the rest of the question:

Please tick in one box to show how you describe your current health:

____1=Very good ____2=Good ____3=Fair ____4=Poor ____5=Very poor

Part 1: Questions about how much chest trouble you have had over the past 3 months:

1. Over the past 3 months, I have coughed:

____a. Most days a week ____b. Several days a week ____c. A few days a month
_____d. Only with chest infections ____e. Not at all

2. Over the past 3 months, I have brought up phlegm (sputum):

____a. Most days a week ____b. Several days a week ____c. A few days a month
_____d. Only with chest infections ____e. Not at all

3. Over the past 3 months, I have had shortness of breath:

____a=Most days a week ____b=Several days a week ____c=A few days a month
_____d=Only with chest infections ____e=Not at all

4. Over the past 3 months, I have had attacks of wheezing:

____a=Most days a week ____b=Several days a week ____c=A few days a month
____d=Only with respiratory infections ____e=Not at all

5. During the past 3 months, how many severe or very unpleasant attacks of chest trouble have you had?

____a=More than 3 attacks ____b=3 attacks ____c=2 attacks
____d=1 attack ____e=No attacks

6. How long did the worst attack of chest trouble last? (*Go to question 7 if you had no severe attacks)*

____a= a week or more ____b= 3 or more days _____c= 1 or 2 days _____d= less than a day

7. Over the past 3 months, in an average week, how many good days (with little chest trouble) have you had?

____ a=No good days ____b=1 or 2 good days ____c= 3 or 4 good days
____d=nearly every day is good ____e= Every day is good

8. If you have a wheeze, is it worse in the morning? ____1=Yes ____0=No

Part 2: Section 1 – Please tick one option

9. How would you describe your chest condition?

____a= The most important problem I have
____b=Causes me quite a lot of problems
____c=Causes me a few problems
____d=Causes no problems

10. If you have ever had paid employment.

____a= My chest trouble made me stop work altogether
____b=My chest trouble interferes with my work or made me change my work
____c=My chest trouble does not affect my work

Part 2: Section 2
Questions about what activities usually make you feel breathless <u>these days</u>

11a. Sitting or lying still	____1=True ____0=False
11b. Getting washed or dressed	____1=True ____0=False
11c. Walking around the home	____1=True ____0=False
11d. Walking outside on level ground	____1=True ____0=False
11e. Walking up a flight of stairs	____1=True ____0=False
11f. Walking up hills	____1=True ____0=False
11g. Playing sports or games	____1=True ____0=False

Part 2: Section 3

Some more questions about your cough and breathless <u>these days</u>

12a. My cough hurts	____1=True ____0=False
12b. My cough makes me tired	____1=True ____0=False
12c. I am breathless when I talk	____1=True ____0=False
12d. I am breathless when I bend over	____1=True ____0=False
12e. My cough or breathing disturbs my sleep	____1=True ____0=False
12f. I get exhausted easily	____1=True ____0=False

Part 2: Section 4

Questions about other effects that your chest trouble may have on you <u>these days</u>

13a. My cough or breathing is embarrassing in public	____1=True ____0=False
13b. My chest trouble is a nuisance to my family, friends or neighbors	____1=True ____0=False
13c. I get afraid or panic when I cannot get my breath	____1=True ____0=False
13d. I feel that I am not in control of my chest problem	____1=True ____0=False
13e. I do not expect my chest to get any better	____1=True ____0=False
13f. I have become frail or an invalid because of my chest	____1=True ____0=False
13g. Exercise is not safe for me	____1=True ____0=False
13h. Everything seems too much of an effort	____1=True ____0=False

Part 2: Section 5

Questions about your medication, if you are receiving no medication go straight to section 6.

14a. My medication does not help me very much	____1=True ____0=False
14b. I get embarrassed using my medication in public	____1=True ____0=False
14c. I have unpleasant side effects from my medication	____1=True ____0=False

14d. My medication interferes with my life a lot	____1=True ____0=False

Part 2: Section 6

These are questions about how your activities might be affected by your breathing.

15a. I take a long time to get washed or dressed	____1=True ____0=False
15b. I cannot take a bath or shower, or I take a long time to do it.	____1=True ____0=False
15c. I walk slower than other people my age, or I stop to rest	____1=True ____0=False
15d. Jobs such as housework take a long time, or I have to stop to rest	____1=True ____0=False
15e. If I walk up one flight of stairs, I have to go slowly or stop	____1=True ____0=False
15f. If I hurry or walk fast, I have to stop or slow down	____1=True ____0=False
15g. My breathing makes it difficult to do things such as walk up hills, carry things upstairs, light gardening such as weeding, dance, play bowls or play golf	____1=True ____0=False
15h. My breathing makes it difficult to do things such as carry heavy loads, dig in the garden or shovel snow, jog or walk 5 miles per hours, play tennis or swim	____1=True ____0=False
15i. My breathing makes it difficult to do things such as very heavy manual work, run, cycle, swim fast or play competitive sports	____1=True ____0=False

Part 2: Section 7

We would like to know how your chest <u>usually</u> affects your daily life.

16a. I cannot play sports or games	____1=True ____0=False
16b. I cannot go out for entertainment or recreation	____1=True ____0=False
16c. I cannot go out of the house to do the shopping	____1=True ____0=False
16d. I cannot do housework	____1=True ____0=False
16e. I cannot move far from my bed or chair	____1=True ____0=False

Here is a list of other activities that your chest trouble may prevent you doing. (You do not have to tick these, they are just to remind you of ways in which your breathlessness may affect you):

- Going for walks or walking the dog
- Doing things at home or in the garden
- Sexual intercourse
- Going out to church, pub, club or place of entertainment
- Going out in bad weather or into smoky rooms
- Visiting family or friends or playing with children

Please write in any other important activities that your chest trouble may stop you doing:

17. Which you think best describes how your chest affects you: ***Please check only one***

____a= It does not stop me from doing anything I would like to do

____b= It stops me from doing one or two things I would like to do

____c= It stops me from doing most of the things I would like to do

____d= It stops me from doing everything I would like to do

Alpha-1 Antitrypsin Deficiency Cohort Exposure Questionnaire

Is this a Baseline visit (Visit #1)?
____ 1= Yes – ***Please complete this questionnaire***
____ 0= No – ***Please skip and go to next questionnaire***

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

- Smoking

1. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes of 12 oz. of tobacco in a lifetime of less than 1 cigarette a day for one year at any time in your life)

____ 1= Yes
____ 0= No – ***Go to Item 7***

2. How old were you when you first started regular cigarette smoking? _____

3. Do you smoke cigarettes (as of one month ago)?

____ 1= Yes
____ 0= No – ***Go to Item 5***

4. How many cigarettes do you smoke per day now? _____

5. How old were you when you completely stopped smoking? _____

6. On average of the entire time you smoked, how many cigarettes did you smoke per day?
_____

7. Have you ever smoked a pipe regularly? (YES means more than 12 oz of tobacco in a lifetime)

____ 1= Yes
____ 0= No – ***Go to Item 13***

8. How old were you when you first started to smoke a pipe regularly? _____

9. Do you smoke a pipe (as of one month ago)?

____ 1= Yes
____ 0= No – ***Go to Item 11***

10. How much pipe tobacco do you smoke per day now? _____ oz per day

11. How old were you when you completely stopped smoking a pipe? _____ years old

12. On average of the entire time you smoked a pipe, how many ounces of tobacco did you smoke per week? _____oz per week

13. Have you ever smoked cigars regularly? (YES means more than 1 cigar a week for one year at any time in your life)

____ 1= Yes
____ 0= No – ***Go to Item 19***

14. How old were you when you first started to smoke cigars regularly? _____

15. Do you now smoke cigars (as of one month ago)?

____ 1= Yes
____ 0= No – ***Go to Item 17***

16. How many cigars smoke per day now? _____ per day

17. How old were you when you completely stopped smoking cigars? _____

18. On average of the entire time you smoked cigars, how many cigars did you smoke per week? _____ per week

- <u>Vaping</u>

19. Have you ever used an electronic cigarette or vaped product?

____ 1= Yes
____ 0=No – ***Go to Item 24***

20. Did your electronic cigarette or vaped product contain any of the substances below?

____ 1= Nicotine
____ 2= Cannabis / marijuana / THC
____ 3= Don't know
____ 4= Other, Please specify other _____

21. Do you still use e-cigarettes or vape products?
____ 1= Yes
____ 0= No – ***Go to Item 23***

22. How often do you use e-cigarettes or vape products?
____ 1= Every day
____ 2= Most days
____ 3= 4+ days a week
____ 4 = 1-3 days a week
____ 5= Less than once a week
____ 6= Less than once a month

23. How many years in total have you used electronic cigarettes or vape products? _____

- Second Hand Smoke

24. Do you currently live in the same household with someone who smokes tobacco products?
____ 1= Yes
____ 0= No

25. Have you ever lived in the same household with someone who smoked tobacco products?
____ 1= Yes
____ 0= No

26. Growing up until age 18, were there any adults in your household who smoked at home?
____ 1= Yes
____ 0= No

27. For how many years in total did you live in the same household with someone else who smoked tobacco products? _____

28. Have you been regularly exposed to tobacco smoke in the last 12 months? ['Regularly' means on most days or nights]
____ 1= Yes
____ 0= No

29. Do people smoke regularly in the room where you work?
____ 1= Yes
____ 0= No

- Occupational

30. What kind of work do you do? What is your occupation? _____

31. Does your current job expose you to vapors, gas, dust or fumes?
____ 1= Yes
____ 0= No
____ 2= I don't know

32. In your longest held job, what kind of work did you do? What was your occupation?
_____

33. Did your longest job expose you to vapors, gas, dust, or fumes?
____ 1= Yes
____ 0= No
____ 2= I don't know

- Home

34. Is an air cleaner/filter used in your residence (stand-alone or central)?
____ 1= Yes
____ 0= No – ***Go to Item 36***

35. If Yes, is it…
____ 1= Stand-alone/portable
____ 2= Central
____ 3= I don’t know

36. Within the last 12 months have you had wet or damp spots on surfaces inside your home other than in the basement (for example on walls, wall paper, ceilings or carpets)?
____ 1= Yes
____ 0= No
____ 2= I don't know

37. Has there ever been any mold or mildew on any surface, other than food, inside the home?
____ 1= Yes
____ 0= No
____ 2= I don't know

38. Do you keep a cat inside the house?
____ 1= Yes
____ 0= No

39. Do you keep a dog inside the house?
____ 1= Yes
____ 0= No

40. Do you keep any birds inside the house?
____ 1= Yes
____ 0= No

- Cleaning chemicals

41. Have you been the person doing the cleaning and/or washing in your home?
____ 1= Yes
____ 0= No

42. Have you worked as a cleaner?
____ 1= Yes
____ 0= No

43. On how many days a week did you use cleaning products?
____ 1= never
____ 2= <1 day/week
____ 3= 1−3 days/week
____ 4= 4−7 days/week

44. On how many days a week did you use cleaning sprays?
____ 1= never
____ 2= <1 day/week
____ 3= 1−3 days/week
____ 4= 4−7 days/week

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

COPD Assessment Test (CAT)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

For each item below, place a mark in the box that best describes your experience.

Example:	I am very happy	0	√ 1	2	3	4	5	I am very sad

I never cough	0	1	2	3	4	5	I cough all the time
I have no phlegm (mucus) in my chest at all	0	1	2	3	4	5	My chest is completely full of phlegm (mucus)
My chest does not feel tight at all	0	1	2	3	4	5	My chest feels very tight
When I walk up a hill or one flight of stairs I am not breathless	0	1	2	3	4	5	When I walk up a hill or one flight of stairs I am very breathless
I am not limited doing any activities at home	0	1	2	3	4	5	I am very limited doing activities at home
I am confident leaving my home despite my lung condition	0	1	2	3	4	5	I am not at all confident leaving my home because of my lung condition
I sleep soundly	0	1	2	3	4	5	I don't sleep soundly because of my lung condition
I have lots of energy	0	1	2	3	4	5	I have no energy at all

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

Shortness of Breath Questionnaire (SOBQ)

Was this questionnaire completed? _____1=Yes _____0=No

If No, please explain: _____

Please check/circle only one

When I do, or if I were to do, the following tasks, I would rate my breathlessness as:

0 ***None at all***

1

2

3

4 ***Severe***

5 ***Maximal or unable to do because of breathlessness***

1. At rest	0	1	2	3	4	5
2. Walking on a level at your own pace	0	1	2	3	4	5
3. Walking on a level with other your age	0	1	2	3	4	5
4. Walking up a hill	0	1	2	3	4	5
5. Walking up stairs	0	1	2	3	4	5
6. While eating	0	1	2	3	4	5
7. Standing up from a chair	0	1	2	3	4	5
8. Brushing teeth	0	1	2	3	4	5
9. Shaving and/or brushing hair	0	1	2	3	4	5
10. Showering/bathing	0	1	2	3	4	5

When I do, or if I were to do, the following tasks, I would rate my breathlessness as:

0 None at all
1
2
3
4 Severe
5 Maximal or unable to do because of breathlessness

11. Dressing……	0	1	2	3	4	5
12. Picking up and straightening ……..	0	1	2	3	4	5
13. Doing dishes ……..	0	1	2	3	4	5
14. Sweeping/vacuuming……..	0	1	2	3	4	5
15. Making bed ……	0	1	2	3	4	5
16. Shopping ……..	0	1	2	3	4	5
17. Doing laundry ……	0	1	2	3	4	5
18. Washing car ……	0	1	2	3	4	5
19. Mowing lawn ……..	0	1	2	3	4	5
20. Watering lawn ……..	0	1	2	3	4	5
21. Sexual activities ……..	0	1	2	3	4	5

How much do these limit you in your daily life?

0 None at all
1
2
3
4 Severe
5 Maximal or unable to do because of breathlessness

22. Shortness of breath ……	0	1	2	3	4	5
23. Fear of "hurting myself" by overexerting ……..	0	1	2	3	4	5
24. Fear of shortness of breath ……..	0	1	2	3	4	5

Modified Medical Research Council Dyspnea Scale (MMRC)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

Please select the statement that best describe your shortness of breath

1. Grade:

____ 0= I only get breathless with strenuous exercise

____ 1= I get short of breath when hurrying on the level ground or walking up on a slight hill

____ 2= On the level ground, I walk slower than people of the same age because of breathlessness or have to stop for breath when walking on my own pace

____ 3= I stop for breath after walking about 100 yards or after a few minutes on the level/

____ 4= I am too breathless to leave the house or I am breathless when dressing.

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

Breathlessness, Cough and Sputum Scale (BCSS)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

1. How much difficulty did you have breathing today?

____ 0= None – unaware of any difficulty

____ 1= Mild – noticeable when performing strenuous activity (e.g., running)

____ 2= Moderate – noticeable even when performing light activity (e.g., bedmaking or carrying groceries)

____ 3= Marked – noticeable when washing or dressing

____ 4= Severe – almost constant, present even when resting

2. How was your cough today?

____ 0= No cough – unaware of coughing

____ 1= Rare – cough now and then

____ 2= Occasional – less than hourly

____ 3= Frequent – one or more times an hour

____ 4= Almost constant – never free of cough or need to cough

3. How much trouble did you have due to sputum today?

____ 0= None – unaware of any trouble

____ 1= Mild – rarely caused trouble

____ 2= Moderate – noticeable trouble

____ 3= Marked – caused a great deal of trouble

____ 4= Severe – almost constant trouble

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

Patient Health Questionnaire (PHQ-9)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

____ 1= Not difficult at all
____ 2= Somewhat difficult
____ 3= Very difficult
____ 4= Extremely difficult

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

Chronic Liver Disease Questionnaire (CLDQ)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

Response Options

1- ***All the time***
2- ***Most of the time***
3- ***A good bit of the time***
4- ***Some of the time***
5- ***A little of the time***
6- ***Hardly any of the time***
7- ***None of the time***

Question							
1. How much of the time during the last two weeks have you been troubled by a feeling of abdominal bloating?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2. How much of the time have you been tired or fatigued during the lasttwo weeks?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3. How much of the time during the last two weeks have you experiencedbodily pain?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4. How often during the last two weeks have you felt sleepy during theday?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5. How much of the time during the last two weeks have you experiencedabdominal pain?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6. How much of the time during the past two weeks has shortness ofbreath been a problem for you and your daily activities?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
7. How much of the time during the last two weeks have you not been ableto eat as much as you would like?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
8. How much of the time in the last two weeks have you been bothered byhaving decreased strength?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
9. How often during the last two weeks have you had trouble lifting orcarrying heavy objects?	**1**	**2**	**3**	**4**	**5**	**6**	**7**

10. How often during the last two weeks have you felt anxious?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
11. How often during the last two weeks have you felt a decreased level ofenergy?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
12. How much of the time during the last two weeks have you felt unhappy?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
13. How often during the last two weeks have you felt drowsy?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
14. How much of the time during the last two weeks have you beenbothered by a limitation of your diet?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
15. How often during the last two weeks have you been irritable?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
16. How much of the time during the last two weeks have you had difficulty sleeping at night?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
17. Set a time during the last two weeks have you been trouble by afeeling of abdominal discomfort?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
18. How much of the time during the last two weeks have you beenworried about the impact your liver disease has on your family?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
19. How much of the time during the last two weeks have you had moodswings?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
20. How much of the time during the last two weeks have you been unableto fall asleep at night?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
21. How often during the last two weeks have you had muscle cramps?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
22. How much of the time during the last two weeks have you been worried that your symptoms will develop into major problems?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
23. How much of the time during the last two weeks have you had a drymouth?	**1**	**2**	**3**	**4**	**5**	**6**	**7**

24. How much of the time during the last two weeks have you felt depressed?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
25. How much of the time during the last two weeks have you beenworried about your condition getting worse?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
26. How much of the time during the last two weeks have you had problems concentrating?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
27. How much of the time have you been troubled by itching during thelast two weeks?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
28. Much of the time during the last two weeks have you been worriedabout never feeling any better?	**1**	**2**	**3**	**4**	**5**	**6**	**7**
29. How much of the time during the last two weeks have you been concerned about the availability of a liver if you need a liver transplant?	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

Short Form Healthy Survey (SF-36)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

Choose one option for each questionnaire item.

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

____ 1= Excellent

____ 2= Very good

____ 3= Good

____ 4= Fair

____ 5= Poor

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

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	1-Yes, limiteda lot	**2- Yes, limiteda little**	**3- No, not limited at all**
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3

5. Lifting or carrying groceries	1	2	3
6. Climbing **several** flights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling, or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	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**?

	Yes	**No**
13. Cut down the **amount of time** you spent on work or otheractivities		
14. **Accomplished less** than you would like		
15. Were limited in the **kind** of work or other activities		
16. Had **difficulty** performing the work or other activities (forexample, it took extra effort)		

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)?

	Yes	**No**
17. Cut down the **amount of time** you spent on work or otheractivities		
18. **Accomplished less** than you would like		
19. Didn't do work or other activities as **carefully** as usual		

20. 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

21. How much **bodily** pain have you had during the **past 4 weeks**?
____ 1= None
____ 2= Very mild
____ 3= Mild
____ 4= Moderate
____ 5= Severe
____ 6= Very severe

22. 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= Slightly
____ 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.

	1- All of the time	**2 - Most of the time**	**3 - A good bit of the time**	**4- Some of the time**	**5- A little of the time**	**6- None of the time?**
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. 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.

	1- Definitely true	**2 – Mostly true**	**3 – Don't know**	**4- Mostly false**	**5- Definitely false**
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

Alcohol Use Disorder Identification Test (AUDIT-C)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

1. How often do you have a drink containing alcohol?

____ 1= Never

____ 2= Monthly or less

____ 3= 2-4 times per month

____ 4= 2-3 times per week

____ 5= 4 or more times per week

2. How many standard drinks containing alcohol do you have on a typical day?

____ 1= 1 or 2

____ 2= 3 or 4

____ 3= 5 or 6

____ 4= 7 to 9

____ 5= 10 or more

3. How often do you have 6 or more drinks on one occasion?

____ 1= Never

____ 2= Less than monthly

____ 3= Monthly

____ 4= Weekly

____ 5= Daily or almost daily

Completion Date (mm/dd/yyyy): _____/_____/_____ Participant ID#: __ __ __ - __ __ __

AlphaNet Exacerbation Questionnaire (ANET)

Was this questionnaire completed? _____1=Yes _____0=No
If No, please explain: _____

1. Over the past year, how many times have you experienced worsening ("exacerbations" or "flares") of your lung problems>

____ 1= Every month

____ 2= Every 3 months

____ 3= Every 4 months

____ 4= Every 6 months

____ 5= Once

____ 6= Never

2. Over the past 2 years, have you coughed up sputum/mucus from your lungs on a regular basis for at least three months each year?

____ 1= Yes

____ 0 = No

3. Over the past month, how many times have you been:

Admitted to the hospital?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**>6**
Admitted to the intensive care unit?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**>6**
Seen in the emergency room?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**>6**
Seen by an MD for an unscheduled office visit?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**>6**

4. If you were hospitalized over the past year, was the primary reason lung related?

____ 1= Yes
____ 0 = No (Skip to Question #5)

4a. If YES – How many total days were you in the hospital this past year? _____

4b. If YES – If you were placed on mechanical ventilation, how many days? _____

5. Have you experienced any worsening of respiratory symptoms (an "exacerbation" or "flare") in the last month?

____ 1= Yes

____ 0 = No (Skip to Question #6)

5a. If YES, approximately for how many days were you sick? _____

5b. How were the symptoms managed? (check ALL that apply)

____ 1= Increased of started inhaled medication

____ 2 = Took a burst of steroid (oral or injected)

____ 3= Took antibiotics

____ 4= Started or increased oxygen

5c. The decision to make these medication changes were made by:

____ 1= a healthcare provider

____ 2= you

6. Have you had any of these symptoms within ***<u>the past month</u>***? (check all that apply)

Symptoms: (past 30 days)	**If 'Yes', Do you have it *<u>now</u>*?**	**More than 1 episode?**	**If 'more than 1 episode' how many?**
____ More shortness of breath	___ Yes ___ No	___ Yes ___No	_____
____ More cough	___ Yes ___ No	___ Yes ___No	_____
____ Increased sputum amount	___ Yes ___ No	___ Yes ___No	_____
____ New wheezing	___ Yes ___ No	___ Yes ___No	_____
____ Worsening of wheezing	___ Yes ___ No	___ Yes ___No	_____
____ Sputum changed color	___ Yes ___ No	___ Yes ___No	_____
____ Fever	___ Yes ___ No	___ Yes ___No	_____

7. Did you have pneumonia over the past month?

____ 1= Yes
____ 0 = No (Skip to Question #8)

7a. If YES, Do you have pneumonia now? ___ Yes ___ No

8. Did you have an upper respiratory infection, cold, or flu-like illness in the last month?

____ 1= Yes
____ 0 = No (Skip to Question #9)

8a. If YES, Do you have the infection now? ___ Yes ___ No

9. How did you manage any lung problems you had this past month? (Check all that apply)

____ 1= I spoke with my regular primary care physician or nurse practitioner
____ 2= I spoke with my pulmonary specialist
____ 3 = I visited a doctor in his/her office
____ 4= I went to an emergency room or urgent care center
____ 5= I treated the problem myself

10. Did you start oxygen or change your oxygen over the past month?

____ 1= Yes
____ 0= No (Skip to END)

10a. If YES, changed over the past month (check all that apply)

____ 1= I started using oxygen
____ 2= I stopped using oxygen
____ 3 = I increased the flow rate of my oxygen
____ 4= I decreased the flow rate of my oxygen
____ 5= I started using oxygen with sleep
____ 6= I started using oxygen with exercise
____ 7= I started using oxygen at rest

END!