Demographic Form

ARC ID _____

Name:_____

Date: _____

Id Copy (Office use only)

Current Address:

Street_____

Apt # _____

City_____

State_____

Zip Code_____

Contact Information:

Phone # - Home _____

Phone # - Cellular _____

May we have your permission to text you? **□ Yes □ No**

Phone # - Work _____

E-Mail Address _____

Demographic Information:

Gender	**☐ Male ☐ Female**
Race	**☐ Caucasian ☐ African American ☐Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ More than one race ☐ Other:** _____
Ethnicity	**☐ Hispanic ☐ Non-Hispanic**

Emergency Contact:

Name			
Address			
Phone # (Daytime)		**Phone # (Evening)**	
Relation			

Additional Contacts**:** Please provide the name, address, and phone #'s of 4 relatives or friends in the event that we cannot locate you or your emergency contact.

	Contact 1	**Contact 2**	**Contact 3**	**Contact 4**
Name				
Address				
Phone #				
Relation				

General Medical History Form

ARC ID _____

Name: _____

Date: _____

For Office Use Only: Place an * next to any item that requires additional comments and make a note in the comment section on page 4.

Please answer the following questions regarding your medical history. Questions about your respiratory history will be included on a different form.

Have you <u>EVER</u> been diagnosed with any the following? If so, please put an approximate start and stop date unless the condition is currently ongoing then, please write *"–" or "n/a"* in the Stop Date section.

Central Nervous System (Please check Y or N and include Start/Stop Date, as necessary)

	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Anxiety						Headaches				
Depression						Stroke				
Epilepsy/Seizures						Sleep Apnea				
Parkinson's						Other Sleep Issues				
Other:										

MD Notes: _____

_____

Eyes/Ears/Nose/Throat (Please check Y or N and include Start/Stop Date, as necessary)

	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Cataracts						Nasal Polyps				
Glaucoma						Hearing Problems				
Rhinitis						Ear Aches				
Sinusitis						Other:				

MD Notes: _____

_____

Endocrine (Please check Y or N and include Start/Stop Date, as necessary)

	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Diabetes						Goiter				
Hypothyroid						Hypoerthyroid				
Other:										

MD Notes: _____

_____

Heart/Vascular (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
						Murmur				
Anemia						Aneurysm				
Heart Attack						Valve Disease				
High Blood Pressure						Rheumatic Fever				
Congestive Heart Failure						Syncope/fainting				
Angina						Other:				

MD Notes: _____

_____

Gastrointestinal (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Ulcer						Bloody Stool				
Constipation						Gall Bladder Problem				
Chronic Diarrhea						Pancreatic Problem				
Hepatitis A/B/C						Indigestion				
Jaundice						Cirrhosis				
Other:										

MD Notes: _____

_____

Musculoskeletal (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Broken Bones						Bursitis				
Back Problems						Tendonitis				
Arthritis						Other:				

MD Notes: _____

_____

Urinary Tract (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Urinary Frequency						Incontinence				
Urgency						Chronic Urinary Tract Infections				
Other:										

MD Notes: _____

_____

Immune/Neoplastic (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Cancer						Leukemia				
Abnormal Growth						Lymphoma				
Tumors						HIV Positive				
Other:										

MD Notes: _____

_____

Skin (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Eczema						Psoriasis				
Melanoma						Skin Cancer				
Other:										

MD Notes: _____

_____

Reproductive (Please check Y or N and include Start/Stop Date, as necessary)										
FEMALES:										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Hysterectomy						Post-Menopausal				
Tubal Ligation						Ovarian Cyst				
Irregular Periods						Ovarian/Uterine Cancer				
Other:										

What method of birth control are you currently using? _____

MD Notes: _____

_____

Reproductive (Please check Y or N and include Start/Stop Date, as necessary)										
MALES:										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Vasectomy						Testicular Cancer				
Prostatitis						Other:				

Have you ever had a skin test for tuberculosis (TB)? YES ☐ NO ☐

⇒ IF YES: When was the test done? _____

What were the results of your test? * POSITIVE ☐ NEGATIVE ☐

⇒ IF POSITIVE: When was the last positive test? _____

ILLNESSES, OPERATIONS, HOSPITALIZATIONS, INJURIES

Please list any major illnesses, operations, hospitalizations, major injuries or other important medical condit that you have had during your lifetime and have NOT listed above.

Major illnesses, operations, hospitalizations, major injuries	*Year*	*Still troublesome/present (Yes/No)*

On average, how much of the following alcoholic beverages do you drink per week?

Glasses of wine: _____ cans/bottles of beer: _____ shots of hard liquor: _____

Has anyone ever told you to cut back on your drinking? YES ☐ NO ☐
Have you ever felt guilty about your drinking? YES ☐ NO ☐
Have you ever missed work or been hospitalized because of your drinking? YES ☐ NO ☐

Do you regularly use marijuana? YES ☐ NO ☐

Do you use any recreational drugs such as cocaine, crack, IV drugs? YES ☐ NO ☐
If yes ⇒ When was the last time? _____

MEDICATION HISTORY

Please list all medications you have taken in the past **6 weeks** including over-the-counter medications, sprays, injections, vaccines, etc.

MEDICATION (e.g. Advair)	**DOSE** (e.g. 500/50)	**FREQUENCY** (e.g. 1 puff Twice/Day)	**START DATE** (e.g. 01/01/2016)	**STOP DATE** (e.g. Current)	**REASON** (e.g. Asthma)

FAMILY HISTORY: Are there any diseases that run in your family?				
Disease	**Yes**	**No**	**Family Member**	**At what age**
Stroke				
Heart Attack				
Angina				
High Blood Pressure				
Diabetes				
Breast Cancer				
Other				
Other				
Other				

Additional Coordinator or Physician Notes/Comments:

Respiratory History Form

Name:_____

Date: _____

For Office Use Only: Place an * next to any item that requires additional comments and make a note in the comment section on page 4.

Please answer the following questions regarding your respiratory health.

	Please indicate if you have EVER had any of the following confirmed by a doctor			
		Yes	**No**	**Unsure**
	Asthma			
	Emphysema			
	Chronic bronchitis			
	Chronic Obstructive Pulmonary Disease (COPD)			
RH1	Eczema			
RH2	Hay Fever			
RH3	Nasal Polyps			
	Pneumonia			
	Acute Bronchitis			
	Tuberculosis			
	Lung Cancer			
	Other			
	I do not have any of these conditions/symptoms			

MD Notes: _____

_____

	Do any of the following cause attacks of wheezing or shortness of breath? (please place an X)					
		Yes	**No**		**Yes**	**No**
RH4	Exercise			Fatigue		
	Colds			Odors		
RH5	Cold Air			Foods		
	Humidity			Stress		
RH6	Aspirin			Other: _____		

If you don't have Asthma please skip to Page 9
(Have you ever been skin tested for allergies?)

RH7 At what age did you first develop asthma? _____ I do not have asthma ☐

	Yes	No	Unsure
Do you produce sputum and/or cough on a daily basis?			
Do you wake up at night because of your respiratory condition or to use your inhaler?			
If yes, how many nights on average do you wake up a week?	_____ **nights**		
Do you need to use oxygen?			
If yes, how much do you use and when?			

Please check the months when your respiratory symptoms are the worst:				
January			July	
February			August	
March			September	
April			October	
May			November	
June			December	

Please check when your daily symptoms are the worst:				
Morning			Night	
Home			Work	
Indoors			Outdoors	

ASTHMA AND ALLERGY MEDICATION HISTORY:
Please list all medications you have taken **for your <u>RESPIRATORY (Allergy and Asthma)</u> condition** in the past 6 wks.

	MEDICATION (e.g. Advair)	**DOSE** (e.g. 500/50)	**FREQUENCY** (e.g. 1 puff Twice/Day)	**START DATE** (e.g. 01/01/2016)	**STOP DATE** (e.g. Current)	**REASON** (e.g. Asthma)
M1						
M2						
M3						
M4						
M5						
M6						

BA On average, how many times per week do you take your "rescue inhaler" (Ventolin, Albuterol, Proair, etc.)?
_____ **times**

Have you EVER taken inhaled corticosteroids (such as Azmacort®, Flovent®, Pulmicort®, Advair®, Symbicort®, Dulera®, Qvar®, Beclovent®, Alvesco®, Azmacort® Breo Ellipta®, Anoro Ellipta® etc.) for your respiratory condition? ☐ **YES** ☐ **NO**

⇒ If YES, list medication and start/stop date:

Medication	Start Date	Stop Date (Write "current" if still taking)

RH8 ***For Office Use Only: Is the participant currently taking inhaled corticosteroids on a regular basis? Yes No***

	Please answer the following questions regarding your respiratory condition/allergy history. (Circle Y/N and fill in blanks as necessary)		
RH8A **RH8B**	Have you ever taken oral steroids (such as prednisone, Medrol, etc.) for your respiratory condition? Have you EVER taken "bursts" of prednisone: If YES: How many times in the last year? _____ How many times in last 10 years? _____ If YES, list medication and start/stop date: Medication / Start Date / Stop Date	**Yes**	**No**
	Have you ever taken steroid shots in your arm or leg for your respiratory condition? If YES, list medication and start/stop date: Medication / Start Date / Stop Date	**Yes**	**No**
	Please answer the following questions regarding your respiratory condition/allergy history. (Circle Y/N and fill in blanks as necessary)		
	Have you ever had to go to the emergency room for your respiratory condition? If YES, when was the last time? How many times in the last year? _____ How many times in last 10 years _____	**Yes**	**No**
RH9	Have you ever had to stay overnight in the hospital for your respiratory condition? If YES, when was the last time? How many times in the last year? _____ How many times in last 10 years? _____	**Yes**	**No**
RH10	Have you ever been intubated (had a tube inserted in your throat to help you breathe) for your respiratory condition? If YES, when was the last time? _____	**Yes**	**No**

Have you ever been skin tested for allergies?	Yes	No

Please check if you have any of the following allergies and describe symptoms:

		Check	What kind?	What symptoms do you experience?
RH11	Animals			
	Poll			
	Dust			
RH12	Food			
	Drugs			

Have you ever received allergy shots? ☐ **YES** ☐ **NO**

If YES, are you still receiving them? ☐ **YES** ☐ **NO**

If NO, when did you stop receiving them? _____

Has anyone in your immediate family ever had:

		Parent	Brother(s)/Sister(s)	Children?
RH13	Asthma			
	Hay Fever			
	Hives			
	Eczema			
	Swelling			

Please answer the following questions regarding your respiratory condition/allergy history. (Circle Y/N and fill in blanks as necessary)

RH14	Have you ever smoked (cigarettes, cigar, pipe)?	**Yes**	**No**
	If NO: Stop here.		
	If YES, Are you a smoker now?	**Yes**	**No**
	If YES: How many packs per day do you smoke?		
	What year did you start smoking?		
	If NO: How many packs per day did you smoke?		
	How many years did you smoke?		
	When was your last cigarette?		
RH15	***Coordinator Use:*** Calculated # of pack years_____(= packs smoked per day x years smoked)		
RH16	***Coordinator Use:*** ***ASTHMA*** ☐ **NORMAL** ☐ **COPD** ☐		

I verify that the above information is accurate. _____
Subject signature **Date**

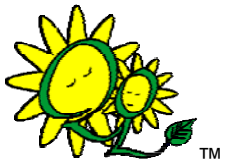
I verify that I have reviewed the above information. _____
Coordinator Signature **Date**

Coordinator Verification of Asthma Medication (must select at least 1 option):

- ☐ **Coordinator saw and photographed inhalers that subject brought in during appointment. Photo will be saved in ARC subject chart**
- ☐ **Subject showed active prescription through patient's medical/pharmacy portal. Snippet was emailed and will be saved in ARC subject chart.**
- ☐ **Coordinator verified/printed active prescription via EPIC/Care Everywhere.**

Coordinator Initials: _____ Date: _____

ASTHMA CONTROL QUESTIONNAIRE



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December 2002

ASTHMA CONTROL QUESTIONNAIRE© PATIENT ID:_____

DATE:_____

Please answer questions 1 - 6.

Circle the number of the response that best describes how you have been during the past week.

1. On average, during the past week, how often were you **woken by your asthma** during the night?

0 Never
1 Hardly ever
2 A few times
3 Several times
4 Many times
5 A great many times
6 Unable to sleep because of asthma

2. On average, during the past week, how **bad were your asthma symptoms when you woke up** in the morning?

0 No symptoms
1 Very mild symptoms
2 Mild symptoms
3 Moderate symptoms
4 Quite severe symptoms
5 Severe symptoms
6 Very severe symptoms

3. In general, during the past week, how **limited were you in your activities** because of your asthma?

0 Not limited at all
1 Very slightly limited
2 Slightly limited
3 Moderately limited
4 Very limited
5 Extremely limited
6 Totally limited

4. In general, during the past week, how much **shortness of breath** did you experience because of your asthma?

0 None
1 A very little
2 A little
3 A moderate amount
4 Quite a lot
5 A great deal
6 A very great deal

5.	In general, during the past week, how much of the time did you **wheeze?**	0 1 2 3 4 5 6	Not at all Hardly any of the time A little of the time A moderate amount of the time A lot of the time Most of the time All the time
6.	On average, during the past week, how many **puffs/inhalations of short-acting bronchodilator** (e.g. Ventolin/Bricanyl) have you used each day? *(If you are not sure how to answer this question, please ask for help)*	0 1 2 3 4 5 6	None 1 - 2 puffs/inhalations most days 3 - 4 puffs/inhalations most days 5 - 8 puffs/inhalations most days 9 - 12 puffs/inhalations most days 13 - 16 puffs/inhalations most days More than 16 puffs/inhalations most days

To be completed by a member of the clinic staff

7.	FEV_1pre-bronchodilator: …… FEV_1predicted:…… FEV_1%predicted:……. (Record actual values on the dotted lines and score the FEV_1 % predicted in the next column)	0 1 2 3 4 5 6	> 95% predicted 95 - 90% 89 - 80% 79 - 70% 69 - 60% 59 - 50% < 50% predicted