Clinical Research Institute

COPD Medical History Form

Please fill out this form as completely as possible and bring it to your first research study appointment.

Name: _____ **Date:** _____

DOB: _____ **(mm/dd/yyyy)** **Gender: Male / Female**

First onset of COPD symptoms _____ **(MONTH / YEAR)** **First diagnosed with COPD** _____ **(MONTH /DAY /YEAR)**

Number of COPD episodes (requiring oral steroids/antibiotics) **in the past 12 months?** _____

Date of most recent COPD episode (comment if estimated date) _____

Type of treatments received for your most recent COPD episode?

Oral corticosteroids (Prednisone) **YES NO** _____
(NAME OF DRUG)

Antibiotics **YES NO** _____
(NAME OF DRUG)

Type of daily COPD symptoms: **Breathlessness** □ with activity □ without activity

Cough **Increased Sputum** **Wheeze** **Night-time awakenings**

Bronchitis **Phlegm** **Dyspnea** **Other** _____

Current smoker YES / NO

Ex-smoker YES / NO Year started_____**Year Quit**_____

If quit smoking more than once please provide those dates also:

Year started_____**Year quit**_____ **Year started**_____**Year quit**_____

Occasional smoker YES / NO **Habitual smoker YES / NO**

Average number of packs smoked per day _____

Do you have any drug allergies? □ No □ Yes- please complete the following:

Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other_____
Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other_____

Have you ever had surgery? ___ No ___ Yes – Date and type of surgery

_____

_____

_____

Have you ever been hospitalized other than for a surgery? ___ No ___ Yes - Date and reason

_____

_____

_____

Please tell us if you currently have or have had a past history of any of the following conditions.
If you answer yes, please circle condition and give dates that the condition started, stopped or if it is continuing.

Ears/Eyes/Throat Problems with your eyes, ears or throat? □ No □Yes _____
Mouth/throat problems (infections, hoarseness)
Cataracts? □ No □Yes _____
Head/Nose □ No □Yes _____
Speech or hearing problems? □ No □Yes _____
Headaches (cluster, tension, migraines) or seizures? □ No □Yes _____
Sinus problems (allergies, loss of smell,
nasal polyps, sinus infections)? □ No □Yes _____
Problems with vision? □ No □Yes _____
Emotional: Do you feel nervous, angry, suicidal, depressed,
lonely, sad or out of control? □ No □Yes _____
Do you have trouble sleeping? □ No □Yes _____
Endocrine: Diagnosed with diabetes? When/type _____ □ No □Yes _____
Do you have thyroid disease? □ No □Yes _____
Circulatory: Heart problems (high blood pressure, palpitations,
chest pain, irregular heart beat)? □No □Yes _____
Respiratory: Lung problems (bronchitis, pneumonia, TB,
asthma)? □ No □Yes _____
Gastrointestinal: Recent problems with eating, drinking? □ No □Yes _____
Problems with nausea, vomiting, abdominal pain,
or bloody stools? □No □ Yes _____
Recent weight changes or change in appetite within
the last 3 months? □ No □Yes _____
Ulcers, hernias, indigestion, cirrhosis, or hepatitis? □ No □Yes _____
Genital/Urinary: Burning, pain or frequency when urinating? □ No □Yes _____
Have you been treated for a sexually transmitted
disease? If yes, what _____ □ No □Yes _____
Have you had kidney stones, prostate infection
(male), or urinary tract (bladder) infection? □ No □Yes _____
Immune: Cancer, blood diseases, deficiencies, anemia? □ No □Yes _____
Mobility: Muscular/joint (i.e. arthritis) bone/orthopedic problems
or difficulty with coordination? □ No □Yes _____
Skin: Problems with your skin (rash, hives, changes in
skin/hair, cold sores, eczema)? □ No □Yes _____

MEDICATIONS –list all medications (including prescription and over-the-counter) used in the past 6 months.

Medication	**Dose**	**Reason for use**	**Date started**	Date stopped
(*example) ibuprofen*	*2-200 mg tabs*	*tension headache*	*April 1, 2009*	*April 2, 2009*