ST. LOUIS COLLEGE *of* PHARMACY

COPD Study in the Community Pharmacy

Participant Questionnaire

(Version 070516)

INSTRUCTIONS:

Please provide the most accurate information possible for every question. NOTE: THE QUESTIONNAIRE IS PRINTED ON BOTH SIDES OF THE PAPER, SO PLEASE ANSWER THE QUESTIONS ON BOTH SIDES OF EACH PAGE. If any question is unclear, please ask the pharmacist who gave you this questionnaire for help. ALL ANSWERS WILL BE KEPT CONFIDENTIAL AND PRIVATE.

1. How confident are you in filling out medical forms by yourself? Please MARK [X] ONLY ONE box.
   - ☐ Extremely
   - ☐ Quite a bit
   - ☐ Somewhat
   - ☐ A little bit
   - ☐ Not at all

The PHARMACIST will ask the questions on the next page.

Patient ID: _____ (For STLCOP Investigator Use Only)

2. **PHARMACIST ONLY—Please collect a medication history *pertaining to drugs used to treat COPD*. Please reconcile the participant's CURRENT medication use with the list of drugs filled at your pharmacy within the past 12 months.**

STEP 1 – Ask participant the open-ended question, "What medications do you currently take for your breathing?" Write their answers in Column A in Table 1 below. Then MARK ONE most appropriate BOX to the right. TABLE 1.

Column A. COPD Medication History (Include drug name, strength, and directions that the participant is CURRENTLY taking)	This matches pharmacy records EXACTLY (IF YES, Mark "X")	DRUG matches, but taking differently than prescribed (Mark "X" and write how prescribed)	Drug is NOT on pharmacy records (Mark "X")

STEP 2 – Ask participant the open-ended question, "Is there any other medication you take for your breathing?" If YES, then write the additions in Column A in Table 1 above, as in STEP 1.

Step 3 – Please refer to your pharmacy's records for this participant. If there are any medications in your pharmacy records that are NOT listed in the table above, then write them in Column A in Table 2 below and MARKING the ONE most appropriate BOX to the right.
TABLE 2

Column A. COPD Medications in Pharmacy Records NOT REPORTED Taken in Table Above (Include drug name, strength, and directions according to your pharmacy records)	This prompt now causes participant to report taking as directed	This prompt now causes participant to report taking it, but differently than prescribed	Physician stopped the medication (NOTE approximate date)	Participant stopped the medication (NOTE approximate date)

3. MARK [X] ONLY ONE box next to the statement that best applies to you regarding your breathing during activity.

- ☐ I only get breathless with strenuous exercise.
- ☐ I get short of breath when hurrying on the level or walking up a slight hill.
- ☐ I walk slower than other people of the same age on the level because of breathlessness, OR I have to stop for breath when walking on my own pace on the level.
- ☐ I stop for breath after walking about 100 yards or after a few minutes on the level.
- ☐ I am too breathless to leave the house, OR I am breathless when dressing or undressing.

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4. For EACH item (each row in the table below), please **CIRCLE the ONE number** that best reflects your breathing currently.

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 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 in leaving my home despite my lung conditions	0 1 2 3 4 5	I am not at all confident in 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

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5. Please MARK [X] ALL boxes that apply to your current use of tobacco and/or nicotine products.
   - ☐ I smoke tobacco (cigarettes, cigars, pipe, OR other)
   - ☐ I use smokeless tobacco (snus, snuff, OR other)
   - ☐ I use electronic (vapor) nicotine
   - ☐ I use a nicotine replacement product (MARK [X] ALL boxes that apply)
     - ☐ Gum (like Nicorette Gum OR Zonnic Gum)
     - ☐ Patch (like NicoDerm OR Habitrol)
     - ☐ Inhaler (like Nicotrol)
     - ☐ Nasal spray (like Nicotrol NS)
     - ☐ Lozenge (like Nicorette Lozenge)
   - ☐ I have never smoked tobacco in the past
   - ☐ I choose to not answer this question

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6. Please MARK [X] ALL boxes that apply regarding your current OR past medical problems.
   - ☐ Heart disease
   - ☐ Lung cancer
   - ☐ Osteoporosis
   - ☐ Depression
   - ☐ Anxiety
   - ☐ Muscle weakness (which limits physical activities)
   - ☐ Metabolic syndrome (combination of **high cholesterol**/lipids, AND **high blood sugar** (diabetes), AND **high blood pressure**, AND **increased waist circumference** [men: 40 inches and women: 35 inches])

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7. In the past 12 months (1 year), how many times have you taken an antibiotic (like Z-Pak, doxycycline, amoxicillin, OR Augmentin) for a COPD flare-up? MARK [X] ONLY ONE box.
   - ☐ 0
   - ☐ 1
   - ☐ 2 OR more

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8. In the past 12 months (1 year), how many times have you taken a steroid (like prednisone, methylprednisone, OR Medrol DosePak) for a COPD flare-up? MARK [X] ONLY ONE box.
   - ☐ 0
   - ☐ 1
   - ☐ 2 OR more

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9. In the past 12 months (1 year), how many times have you been admitted to a hospital OR received care in an emergency room/department for a COPD flare-up? MARK [X] ONLY ONE box.
   - ☐ 0
   - ☐ 1
   - ☐ 2 OR more

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10. Have you had a formal breathing test (like a pulmonary function test OR a spirometry test) anytime within the past 3 years. MARK [X] ONLY ONE box.
    - ☐ Yes
    - ☐ No

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11. What is your sex? MARK [X] ONLY ONE box.
    - ☐ Male
    - ☐ Female
    - ☐ I choose to not answer this question

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12. What type(s) of health insurance coverage do you CURRENTLY have? MARK [X] ALL boxes that apply.
    - ☐ Medicare
    - ☐ Medicaid (also called MO HealthNet)
    - ☐ Private managed health insurance plan (any HMO, PPO, Exchange, OR supplemental plan)
    - ☐ Other
    - ☐ I have NO health insurance at all
    - ☐ I choose to not answer this question

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13. From what source(s) do you obtain your COPD medications? MARK [X] ALL boxes that apply.
    - ☐ At this pharmacy, through my insurance and with a copay/coinsurance
    - ☐ At this pharmacy, by paying full price with cash
    - ☐ Sample medications, from my doctor's office
    - ☐ Patient assistance program, through the drug company/manufacturer
    - ☐ Family member OR friend
    - ☐ I choose to not answer this question

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14. Approximately how much money do you spend out of pocket per MONTH **for your COPD medications**?

    _____

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15. Approximately how much money do you spend out of pocket per MONTH **for ALL of your medications**?

    _____

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16. What is your ethnicity? MARK [X] ONLY ONE box.
    - ☐ Hispanic or Latino (person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
    - ☐ NOT Hispanic or Latino
    - ☐ I do not know my ethnicity
    - ☐ I choose to not answer this question

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17. What is your race? MARK [X] ALL boxes that apply.

- ☐ American Indian or Alaska Native (person with origins in any of the original people of North and South America, including Central America, who maintains cultural identification through tribal affiliation or community attachment)
- ☐ Asian (person with origins in any of the original people of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)
- ☐ Native Hawaiian or Other Pacific Islander (person with origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands)
- ☐ Black or African American (person with origins in any of the black racial groups of Africa)
- ☐ White (person having origins in any of the original people of Europe, the Middle East, or North Africa)
- ☐ I do not know my race
- ☐ I choose to not answer this question

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18. Are you currently under the care of a lung specialist doctor (also called a pulmonologist). MARK [X] ONLY ONE box.

- ☐ No
- ☐ Yes (If yes, then please provide name of your lung doctor)

_____
(Lung doctor's FIRST name)

_____
(Lung doctor's LAST name)

19. What is your current height?

_____ _____
(Feet) (Inches)

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20. What is your <u>current</u> weight?

_____
(Pounds)

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21. What is your name (please use the name listed **on your prescription medications**)?

_____
(FIRST Name)

_____
(MIDDLE Name)

_____
(LAST Name)

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22. What is your date-of-birth (DOB)?

_____
(Month-Day-Year)

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23. What is the address of your **<u>current residence</u>**? NOTE: This will only be used to <u>mail your $10 check for participating in this study</u>.

_____
(Include Street Number, Street Name, Apartment Number, P.O. Box, etc.)

_____
(City)

_____
(State)

_____
(ZIP Code)

24. In case we need to contact you to clarify any answers you provide in this questionnaire, what is the **best phone number** we can use to call you?

_____

Best Phone Number (xxx-xxx-xxxx)

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25. What is an alternative or secondary phone number that we can use to call you?

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Alternate Phone Number(xxx-xxx-xxxx)

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26. What is your email address (this will only be used if we cannot reach you by phone)?

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(Email address)

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* * *END of Questionnaire* * *
