

Multi-Ethnic Study of Atherosclerosis



Spirometry Questionnaire

Interviewer Administered

Participant Id#:

Acrostic:

Date:

Month

Day

Year

We would like to ask you some questions about issues that may be related to your breathing. Please answer to the best of your knowledge.

The following questions are about respiratory or chest symptoms. If you are in doubt whether your answer is yes or no, please answer no.

1 Do you usually have a cough on most days for 3 or more months during the year?
o Yes -> For how many years have you had this cough? [ ] [ ] years
o No

2 Do you usually bring up phlegm from your chest on most days for 3 or more months during the year?
o Yes -> For how many years have you brought up phlegm from your chest like this? [ ] [ ] years
o No

3 Have you ever had wheezing or whistling in your chest?
o Yes -> Did you ever have wheezing or whistling in your chest when you were...
younger than 2 years old? o Yes o No o Don't know
2 - 18 years old? o Yes o No o Don't know
older than 18 years old? o Yes o No o Don't know
o No In the last 12 months, have you had wheezing or whistling in your chest?
o Yes
o No -> Skip to question 4
In the last 12 months, how often have you had this wheezing or whistling?
(Read the options) o most days or nights o a few days or nights a week o a few days or nights a month o a few days or nights a year
In the last 12 months, have you had an attack of wheezing or whistling in the chest that has made you feel short of breath?
o Yes
o No

4 Have you ever had a problem with sneezing, or a runny or blocked nose when you did not have a cold or the flu?
o Yes
o No

5 Is your breathing currently worse than usual? o Yes o No

The following questions are about respiratory conditions.

6 Have you ever had hay fever (allergies involving the nose and/or eyes)?

- Yes       No       Don't know

7 Did you have respiratory problems before the age of 16 years?

- Yes       No       Don't know

8 Have you ever had asthma?

- Yes →  
 No

For some people, asthma symptoms completely go away as they grow older. Later in life, however, asthma may recur. At approximately what ages did you experience each of the following events?

- |  |   |  |                                  |
|--|---|--|----------------------------------|
| Age developed first asthma symptoms                              | <input type="text"/> <input type="text"/> years | <input type="radio"/> As a child (age not known)                                     | <input type="radio"/> Don't know |
| Age doctor first diagnosed asthma                                | <input type="text"/> <input type="text"/> years | <input type="radio"/> Never diagnosed by a doctor                                    | <input type="radio"/> Don't know |
| Age at start of 10 year (or more) period without asthma symptoms | <input type="text"/> <input type="text"/> years | <input type="radio"/> Not applicable (symptoms never went away for 10 or more years) | <input type="radio"/> Don't know |
| Age at first recurrence of asthma symptoms                       | <input type="text"/> <input type="text"/> years | <input type="radio"/> Not applicable   | <input type="radio"/> Don't know |

9 Has a doctor ever told you that you had any of the following:

Pneumonia or bronchopneumonia?

- Yes →  
 No  
 Don't know

At about what age did you first have it?   age in years  
How many times have you had pneumonia or bronchopneumonia?   times

Chronic bronchitis?

- Yes →  
 No  
 Don't know

At about what age did it start?   age in years  
Do you still have it?       Yes       No       Don't know

Chronic obstructive pulmonary disease or COPD?

- Yes →  
 No  
 Don't know

At about what age did it start?   age in years

Pulmonary fibrosis or IPF?

- Yes       No       Don't know

Other chest or lung illnesses, operations or injuries?

- Yes       No       Don't know

if yes, please specify:

The following questions are about exposure to smoke.

10 In your childhood, did you live with a regular cigarette smoker who smoked in your home?

- Yes →
- No
- Don't know

In your childhood, how many smokers lived in your home?

persons

11 As an adult, have you ever lived with a regular cigarette smoker (not including yourself) who smoked in your home?

- Yes →
- No
- Don't know

As an adult, for how many total years did you live with them when they were smoking?

years

12 As an adult, have you ever regularly spent time, when you were not at home, indoors where people were smoking cigarettes (for example, at work)?

- Yes →
- No
- Don't know

As an adult, for how many total years have you spent time, when you are not at home, indoors where people were smoking cigarettes?

years

13 Have you ever been exposed at work to:

Vapors or gas

- Yes
- No
- Don't know

Dust

- Yes
- No
- Don't know

Fumes

- Yes
- No
- Don't know

If yes to any →

For how many years were you exposed at work to vapors, gas, dust or fumes?

years

How long ago was your last exposure?

current OR  months OR  years

Was the exposure:  mild  moderate  severe

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

- Yes →
- No
- Don't know

On the average of the entire time you smoked...

a. How many cigarettes did you smoke per day?

cigarettes

b. Did you inhale the cigarette smoke?  
(Read the options)

- Not at all
- Moderately
- Slightly
- Deeply

c. In the morning, how much time after you woke up did you smoke your first cigarette?

hours  minutes

Please answer the following questions about your family history of respiratory conditions.

**15** For each specific disease or condition, you are asked if your relative has ever been told by a doctor if they have had it, and if so, the age at which it occurred, and if they ever smoked cigarettes.

*If response to "blood relation is "Yes" or "Don't Know", continue and obtain history. If "No", skip to the next relation. For siblings and children, start with the first born (oldest) and continue to the last born (youngest). Use supplemental sheets if necessary. Always bubble in appropriate response. Enter Y for YES, N for NO, D for DON'T KNOW. If YES to specific disease or condition, enter approximate AGE at first diagnosis or first occurrence.*

	Blood relation	Chronic bronchitis	Emphysema	Chronic obstructive pulmonary disease (COPD)	Did or does he/she smoke cigarettes?
Spouse		Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
Father	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
Mother	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
Siblings	1. Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
	2. Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
	3. Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
Children	1. Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
	2. Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>
	3. Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/> <input type="text"/> <input type="text"/> Age	Y <input type="radio"/> N <input type="radio"/> D <input type="radio"/>

**16** Have you taken any inhalers, "puffers" or inhaled corticosteroids in the last three days (for example, albuterol [Ventolin, Proventil], salmeterol [Serevent], ipratropium [Atrovent, Combivent], tiotropium [Spiriva], Advair, Aerobid, Azmacort, Beclovent, Flovent, Pulmicort, or Vanceril)?

Yes →  No

Name of Medication	Day that you last took?	Time that you last took?
<input type="text"/>	<input type="radio"/> Day before yesterday <input type="radio"/> Yesterday <input type="radio"/> Today	<input type="text"/> : <input type="text"/> <input type="text"/> M
<input type="text"/>	<input type="radio"/> Day before yesterday <input type="radio"/> Yesterday <input type="radio"/> Today	<input type="text"/> : <input type="text"/> <input type="text"/> M
<input type="text"/>	<input type="radio"/> Day before yesterday <input type="radio"/> Yesterday <input type="radio"/> Today	<input type="text"/> : <input type="text"/> <input type="text"/> M
<input type="text"/>	<input type="radio"/> Day before yesterday <input type="radio"/> Yesterday <input type="radio"/> Today	<input type="text"/> : <input type="text"/> <input type="text"/> M

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Interviewer ID:

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