SPIROMICS
SubPopulations and InteRmediate Outcome Measures In COPD Study

FOLLOW-UP MEDICATION USE

ID NUMBER:									

FORM CODE: MEF
VERSION: 2.0 05/08/2025

Event: _____

0a) Date of Collection: ☐☐ / ☐☐ / ☐☐☐☐ 0b) Staff Code: ☐☐☐

Instructions: *This form should be completed during the participant's clinic visit. List all non-study medications that the participant is currently taking with regularity. Do NOT list medications that are taken "as needed" (PRN), unless they are taken at least once per week.*

AFTER you have entered all of the medications that the participant reports at this visit, please compare what is on this form with what is on the SIII Medication Tracking Report in CDART. For any medications listed on the report that the participant did not mention today, please ask if they are still using that medication regularly. If yes, enter the medication(s) on this form.

1) Are you regularly using any medication(s)?

☐ No$_0$ → **Go to 18**

☐ Yes$_1$

1a) Total number of medications: ☐☐

MEDICATION RECORD

*Begin entering the **Coded Medication Name** into **item (a)** and select the matching medication name (and dosage, if known). If the medication name is not found in the coding dictionary, enter the **Uncoded Medication Name** into **item (b)**. Enter the dosage **Strength** and **Units** in **item (c)** and **item (d)**, respectively, for all uncoded medications.*

2)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
3)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
4)	**(a) Coded Medication Name**		

	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
5)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
6)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
7)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
8)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
9)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**

10)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
11)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
12)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
13)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**

NOTE: Questions 20-27 are out of order numerically because they were added after the initial version of the MEF was released.

20)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
21)	**(a) Coded Medication Name**		

	(b) Uncoded Medication Name	(c) Strength	(d) Units
22)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
23)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
24)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
25)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
26)	**(a) Coded Medication Name**		
	(b) Uncoded Medication Name	**(c) Strength**	**(d) Units**
27)	**(a) Coded Medication Name**		

	(b) Uncoded Medication Name	(c) Strength	(d) Units

14) Are any of the medications you take for: *(If Yes, verify that the **Medication Name** is on the medication record.)*

	No$_0$	Yes$_1$	Don't know$_2$
14a) Asthma	☐	☐	☐
14b) Chronic bronchitis or emphysema	☐	☐	☐
14c) High blood sugar or diabetes	☐	☐	☐
14d) High blood pressure or hypertension	☐	☐	☐
14e) High blood cholesterol	☐	☐	☐
14f) Chest pain or angina	☐	☐	☐
14g) Abnormal heart rhythm	☐	☐	☐
14h) Heart failure	☐	☐	☐
14i) Blood thinning	☐	☐	☐
14j) Stroke	☐	☐	☐
14k) Mini-stroke or TIA	☐	☐	☐
14l) Leg pain while walking or claudication	☐	☐	☐
14m) Other	☐	☐	☐

14m1) Please specify other: _____N

Note: Questions 15-17 have been removed.

18) Are you currently using any oral antioxidant supplements (listed below)?

☐ No$_0$ → **Go to 19**
☐ Yes$_1$

If Yes, please indicate which supplement(s) you use regularly? *(check all that apply)*

18a) ☐ Vitamin A (beta carotene)

18b) ☐ Vitamin C (ascorbic acid)
18c) ☐ Vitamin D (cholecalciferol)
18d) ☐ Vitamin E (alpha-tocopherol)
18e) ☐ Zinc
18f) ☐ Copper
18g) ☐ Fish oil
18h) ☐ Omega 3
18i) ☐ Other

18i1) Please specify other: _____

19) Are you currently using or have you used any other medications (prescribed or over the counter) or supplements regularly that are not listed above?

☐ No$_0$ → **Go to End**
☐ Yes$_1$

If Yes, please list any other medications (prescribed or over the counter) or supplements not listed above:

19a) _____
19b) _____
19c) _____
19d) _____
19e) _____

END OF FORM