

6 Month Follow Up Form

Section 1 - Participant Details

Patient Trial Number: <input type="text"/>	Initials: First, Middle, Last <input type="text"/>	Site Name: <input type="text"/>
Date of patient contact: e.g. 31-Dec-2017 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Section 2 - Symptom Criteria (during the last 5 days)

Have you had worsening shortness of breath?	<input type="radio"/> No <input type="radio"/> Yes
Shortness of Breath Category: <i>Please tick one</i>	
<input type="radio"/> Category 0, No dyspnoea <input type="radio"/> Category 1, Slight degree of dyspnoea (troubled by shortness of breath when hurrying on the level or walking up a slight hill) <input type="radio"/> Category 2, Moderate degree of dyspnoea (walks slower than people of the same age on the level because of breathlessness) <input type="radio"/> Category 3, Moderately severe degree of dyspnoea (has to stop because of breathlessness when walking at own pace on the level) <input type="radio"/> Category 4, Severe degree of dyspnoea (stops for breath after walking about 100 yards or after a few minutes on the level) <input type="radio"/> Category 5, Very severe degree of dyspnoea (too breathless to leave the house or breathless when dressing or undressing)	
Have you been producing more sputum?	<input type="radio"/> No <input type="radio"/> Yes
Has your sputum become thicker/become a deeper colour?	<input type="radio"/> No <input type="radio"/> Yes
Have you had a chest/throat infection?	<input type="radio"/> No <input type="radio"/> Yes
Have you had a fever with no apparent cause?	<input type="radio"/> No <input type="radio"/> Yes
Have you noticed that you're breathing faster or that your heart feels it's beating quicker than normal?	<input type="radio"/> No <input type="radio"/> Yes

Section 3 - Flare ups (exacerbations)

How many exacerbations have you had <i>in the last 3 months</i> ?	<input type="text"/> exacerbations
How many exacerbations required hospitalisation <i>in the last 3 months</i> ?	<input type="text"/> hospitalisations
Attended pulmonary rehabilitation?	<input type="radio"/> No <input type="radio"/> Yes
If "yes", most recent date:	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Have you had non-invasive ventilation?	<input type="radio"/> No <input type="radio"/> Yes

Section 4 - Lifestyle Factors

Current Smoking Status: <i>Please tick one</i>
<input type="radio"/> Never <input type="radio"/> Current smoker <input type="radio"/> Stopped < 6 weeks ago <input type="radio"/> Stopped ≥6 weeks to < 1 year ago <input type="radio"/> Stopped ≥1 year ago

Section 5 - Patient Completed Questionnaire Booklet

Have you completed the 6 month questionnaire booklet?	<input type="radio"/> No <input type="radio"/> Yes
If no, please provide reason	
<input type="text"/>	

Section 6 - Form Completion Details

Completed By:	Signature:	Date: e.g. 31-JAN-2017 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Principal Investigator Name:	Principal Investigator Signature:	Date: e.g. 31-JAN-2017 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>