DEMOGRAPHIC-ASTHMA QUESTIONNAIRE
Ethnic Symptom Descriptors in Mild Asthmatics

** A copy of the consent form has been provided to you; if you have any questions or concerns about participating in this study please discuss these concerns with your primary MD.**

Date:______________

Name:___________________________________________________________________________

Address:_________________________________________________________________________

City:_______________________________________ CA Zip:________________________________

Telephone:_______________________(H)____________________(W)

Social Security #:_____________ DOB:____________ Gender: M/F______

Do you plan to move in the near future: Yes/ No * please circle the correct response

Recruitment source: _____Campus_____Newspaper_____Clinic_____Other

Ethnic Origin: ____Black African American, not of Hispanic origin

____White, not of Hispanic origin

_____Latino, Hispanic, Mexican American, and Cuban

____Asian, Pacific Islander, Vietnamese, and Chinese

____ Other

What is your occupation or usual work?________________________________________________

SMOKING HISTORY Have you or do you smoke? Yes/ No

Cigarettes:________packs/day Cigars:____#/day/week/month Pipe:____oz/day/week/month

Other (non-tobacco recreational inhalants):_____________________________________________

Quantity smoked:________per day/week/month

When did you begin (age)?__________ When did you stop (age)?____________

MEDICAL HISTORY

Do you have a history of the following illnesses? Circle the correct response

Adapted from UCSF Asthma Characterization Questionnaire: GEH/11.28.00
6.16.03
DEMOGRAPHIC-ASTHMA QUESTIONNAIRE
Ethnic Symptom Descriptors in Mild Asthmatics

Asthma                       yes/no    Emphysema                   yes/no
Allergies                    yes/no    Hay Fever                     yes/no
Chronic Bronchitis    yes/no    Heart Disease                 yes/no
Diabetes                      yes/no    High Blood Pressure      yes/no
Sinusitis                     yes/no    Tuberculosis                  yes/no

Other medical problems?________________________________________________________

Have you had an upper respiratory infection (cold/flu) during the past 4 weeks?
Yes_________No_______ Are you fully recovered: Yes / No

OTHER  pregnancy is an exclusion for this study, the questions are necessary to determine your eligibility

Do you plan to become pregnant in the next 3-6 months? Yes / No    NA_______

Do you use birth control? Yes / No    Method:______________________________

Are you post-menopausal?    Yes / No    If so how many years past?_______________

Have you had a hysterectomy/tubal ligation?    Yes / No    When/Where______________

MEDICATION

Are you taking any prescription medication (including inhalers)?    Yes / No

Please list the medications (both prescription and over the counter) that you take.

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from UCSF Asthma Characterization Questionnaire: GEH/11.28.00
6.16.03
DEMOGRAPHIC-ASTHMA QUESTIONNAIRE
Ethnic Symptom Descriptors in Mild Asthmatics

Medications: continued

6.________________________________________________________________________

Have you ever taken any steroid pills such as prednisone by mouth at any time for your asthma?
Yes / No        If yes, then when and what was the dose?___________________________

Have you taken any course of prednisone or steroid tablets in the past year?  Yes / No
If yes, when________________

Does anyone else in your family have Asthma?   Yes / No   if yes, who?______________

ASTHMA DIAGNOSIS

How old were you when you had your first attack of asthma?__________________________

How old were you when you were first told by your doctor that you had asthma?__________

At what age did your asthma start to trouble you as an adult? _________________________

ASTHMA SYMPTOMS  (please circle the correct response)

1. Over the past two weeks, would you describe your asthma as:  very severe (5)  severe (4)
moderate (3)  mild (2)  very mild (1)  absent (0)

2. Over the past two weeks, would you say that your asthma has bothered you: every day (4)
most, but not all days  (3)  occasionally, but not most day  (2) hardly any days (1) no days (0)

3. When you are near animals (e.g cats, dogs, horse) near feathers (including pillows, quilts, or
comforters) or in a dusty part of the house do you ever:

3.1. Start to cough               Yes________No_______

3.2. Start to wheeze        Yes________No_______

3.3. Get a tired feeling in your chest?          Yes_________No______

3.4. Develop a runny, a stuffy nose or sneeze?     Yes_________No______

Adapted from UCSF Asthma Characterization Questionnaire: GEH/11.28.00
6.16.03
3.5. Develop itchy or watery eyes?       Yes_________No_____

4. Have you ever been admitted to the hospital for your asthma? Yes______No_____
If yes, when and where ___________________________ date ______________________

5. Have you ever been in an intensive care unit for your asthma? Yes______No______
If yes, when and where ___________________________ date ______________________

6. Have you ever had a tube put in to your throat or been on a mechanical respirator to help you breathe because of your asthma? Yes__No____ If yes, when/where/date ________________________________

7. How many times in the past 2 years have you been to the emergency room for treatment of your asthma? Number of times__________

8. How many times in the past 2 years have you had to go to your doctor's office for urgent treatment of your asthma? Number of times______________

9. How many days in the past year have you not been able to work or go to school because of your asthma? Number of times___________________________

10. Do you wheeze during exercise or right after exercise? Yes / No Which________

11. Does exercise make your asthma worse? Yes / No _______________

12. Does your asthma wake you up at night? Yes / No _______________

13. How many times does your asthma wake you up at night? None/ times ________________

14. If you wake up at night with asthma what do you take? ________________

15. When your asthma is "bad" does it wake you up at night? Yes / No

16. Do you cough? Daily_______Nightly_________Occasionally_____Not at all__________

17. Do you cough first thing in the morning? Yes / No

18. Do you cough up phlegm? Daily______Nightly_______Occasionally_______Not at all______
19. Do you cough up phlegm when your asthma is "bad"? Yes / No

20. Do you bring up phlegm on most days for 3 consecutive months during the last 12 months? Yes / No

21. Do you have a peak flow meter that you use? Yes / No Type_________________

22. What is your best peak flow measurement?_____________________________________________

23. What is your usual/average morning peak flow (before you use your inhalers)? _______ liters/min

24. What is your usual/average evening peak flow (before you use your inhalers)? _______ liters/min

25. Are you presently experiencing an exacerbation (increase asthma symptoms)?
   Yes______ No_______

26. When you have an asthma attack do they come on: over minutes _________
   over hours _________
   over days _________
   over weeks _________

27. Are your attacks precipitated (caused) by:
   a head cold _________
   a chest cold _________
   exercise___________
   allergies___________

28. If allergies, please specify allergen (including foods):
   _________________________________________________________________________________
   _________________________________________________________________________________

29. Otherwise what do you believe makes your asthma worse: ________________________________

30. Did you take an antibiotic when you had this attack? Yes / No Name________________________

MEDICAL CARE

Do you have a regular doctor that you see for your asthma? Yes_____ No_______

What is his/her name?____________________________________________ telephone#________________________

Adapted from UCSF Asthma Characterization Questionnaire: GEH/11.28.00
6.16.03
Where do you receive your care? Check the appropriate response

Doctors office________ Clinic_________ Free Clinic_____________ VAMC__________

Family Medicine Clinic____ Speciality Clinic_____ Emergency Room____ UCSF_______

Other__________________________________________________________________________

Comments:________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Adapted from UCSF Asthma Characterization Questionnaire: GEH/11.28.00
6.16.03