

Dataset name: spir_v2.5

Participant ID pid Acrostic acrostic
Interviewer compby V.C. vc
Date of Visit vis_dat (mm/dd/yyyy)

Spirometry & MIP Data Collection Form

CRF 2.5

1. Have you been told that you had a heart attack or stroke in the last 3 months?
hastroke_spir
-9 ---Select---
1 Yes »
0 No (Go to Q2)
-8 Don't Know »
-7 Refused »
-6 Permanently Missing
---Select---
DO NOT PERFORM SPIROMETRY OR MIP TESTING
2. Have you had eye, chest or stomach surgery or eye injection in the last 3 months?
hadsurg_spir
-9 ---Select---
1 Yes »
0 No (Go to Q3)
-8 Don't Know »
-7 Refused »
-6 Permanently Missing
---Select---
DO NOT PERFORM SPIROMETRY OR MIP TESTING
3. Have you had any significant problems doing spirometry or MIP testing in the past?
pastprob_spir
-9 ---Select---
1 Yes »
0 No (Go to Q4)
-8 Don't Know »
-7 Refused »
-6 Permanently Missing
---Select---
DO NOT PERFORM SPIROMETRY OR MIP TESTING
4. Did you have any caffeinated coffee, tea, or cola, or other caffeinated drink in the past 2 hours
caffeine_spir
-9 ---Select---
1 Yes
0 No
-8 Don't Know
-7 Refused
-6 Permanently Missing
---Select---
5. Did you smoke a cigarette, pipe or cigar during the last hour?
smoke_spir
-9 ---Select---
1 Yes
0 No
-8 Don't Know
-7 Refused
-6 Permanently Missing
---Select---
6. Have you had a respiratory infection in the past 2 weeks, for instance, cold, flu, bronchitis, or pneumonia?
respinf_spir
-9 ---Select---
1 Yes
0 No
-8 Don't Know
-7 Refused
-6 Permanently Missing

---Select---

7. Was the participant able to complete spirometry and MIP testing?

Spirometry:

spirtest_spir

-9 -
1 Yes »
0 No (specify reasons below)
-6 Permanently Missing

-

If No: spirtestreas_spir

**** These fields no longer
entered as of 12/12/2011 ****

FEV6 Best Value (Liters)	fev6best_spir
FEV6 % predicted Best Value	fev6predbest_spir %
FEV1 Best Value (Liters)	fev1best_spir
FEV1 % predicted Best Value	fev1predbest_spir %
FEV1/FEV6 (use above best values)	fev61best_spir (x.xx)

MIP:

Trials: miptest_spir

-9 -
1 Yes »
0 No (specify reasons below)
-6 Permanently Missing

-

1. _____ If No: miptestreas_spir

2. _____
3. _____
4. _____
5. _____

**** These fields no longer
entered as of 12/12/2011 ****

MIP Reading Highest Value (cm H2O)	miphigh_spir
MIP Reading 2nd Highest Value (cm H2O)	mip2ndhigh_spir

ALERT VALUES

If the BEST value for the Forced Expiratory Volume in 1-Second (FEV1) or the BEST value for the Forced Expiratory Volume in 6-Seconds (FEV6) is less than 50 %Predicted, the participant will need to be examined by a qualified LIFE staff member who will evaluate the patient for signs of respiratory distress (i.e., severe shortness of breath), as well as initiate a referral to the primary care provider for further evaluation and management.

No alert values are required for the MIP testing.

If spirometry or MIP not completed, specify the reason(s) below as to why the spirometry or MIP was not completed

Spirometry:

spirrefused_spir value="1" ☐
Refused

spirphyunable_spir value="1" ☐
Physically Unable

spircogunable_spir value="1" ☐
Cognitively Unable

spirequip_spir value="1" ☐

Equipment Problem

spirother_spir value="1" ☐
Other »

Specify: spirotherspec_spir

MIP:

miprefused_spir value="1" ☐
Refused

mipphyunable_spir value="1" ☐
Physically Unable

mipcogunable_spir value="1" ☐
Cognitively Unable

mipequip_spir value="1" ☐
Equipment Problem

mipotherspir value="1" ☐
Other »

Specify: mipotherspec_spir

Source Form Language: lang

-9 -
1 English
2 Spanish

Participant ID (affix ID label here)	LIFE	Acrostic	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Interviewer	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Visit Code:	<input type="text"/> <input type="text"/> <input type="text"/>	
					Date of Visit	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
					month	day	year	

Spirometry & MIP Data Collection Form

1. Have you been told that you had a heart attack or stroke in the last 3 months?	<input type="checkbox"/> Yes → <input type="checkbox"/> No (Go to Q2) <input type="checkbox"/> Don't Know → <input type="checkbox"/> Refused →	DO NOT PERFORM SPIROMETRY OR MIP TESTING										
2. Have you had eye, chest, or stomach surgery or eye injection in the last 3 months?	<input type="checkbox"/> Yes → <input type="checkbox"/> No (Go to Q3) <input type="checkbox"/> Don't Know → <input type="checkbox"/> Refused →	DO NOT PERFORM SPIROMETRY OR MIP TESTING										
3. Have you had any significant problems doing spirometry or MIP testing in the past?	<input type="checkbox"/> Yes → <input type="checkbox"/> No (Go to Q4) <input type="checkbox"/> Don't Know → <input type="checkbox"/> Refused →	DO NOT PERFORM SPIROMETRY OR MIP TESTING										
4. Did you have any caffeinated coffee, tea, or cola, or other caffeinated drink in the past 2 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused										
5. Did you smoke a cigarette, pipe or cigar during the last hour?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused										
6. Have you had a respiratory infection in the past 2 weeks, for instance, cold, flu, bronchitis, or pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know <input type="checkbox"/> Refused										
7. Was the participant able to complete spirometry and MIP testing?												
Spirometry:	<input type="checkbox"/> Yes → <input type="checkbox"/> No (specify reasons below)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">FEV6 Best Value (Liters)</td> <td style="width: 30%; text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td>FEV6 % predicted Best Value</td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % </td> </tr> <tr> <td>FEV1 Best value (Liters)</td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td>FEV1% Predicted Best Value</td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % </td> </tr> <tr> <td>FEV1/FEV6 (use above best values)</td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> </tr> </table>	FEV6 Best Value (Liters)	<input type="text"/> <input type="text"/> <input type="text"/>	FEV6 % predicted Best Value	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> %	FEV1 Best value (Liters)	<input type="text"/> <input type="text"/> <input type="text"/>	FEV1% Predicted Best Value	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> %	FEV1/FEV6 (use above best values)	<input type="text"/> <input type="text"/>
FEV6 Best Value (Liters)	<input type="text"/> <input type="text"/> <input type="text"/>											
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FEV1/FEV6 (use above best values)	<input type="text"/> <input type="text"/>											

<div style="border: 1px solid black; padding: 10px; margin: 0 auto; width: 80%;"> Participant ID (affix ID label here) </div>	<h1 style="margin: 0;">LIFE</h1>	Acrostic <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
		Visit Code <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>

Question 7 continued	
<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <input type="checkbox"/> Yes → <input type="checkbox"/> No (specify reasons below) </div> <div style="width: 55%;"> MIP Reading Highest Value (cm H2O) <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> </div> </div> <div style="margin-top: 10px;"> MIP: <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> </div>	MIP Reading 2 nd Highest Value (cm H2O) <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
ALERT VALUES If the BEST value for the Forced Expiratory Volume in 1-Second (FEV1) or the BEST value for the Forced Expiratory Volume in 6-Seconds (FEV6) is less than 50 %Predicted , the participant will need to be examined by a qualified LIFE staff member who will evaluate the patient for signs of respiratory distress (i.e., severe shortness of breath), as well as initiate a referral to the primary care provider for further evaluation and management. No alert values are required for the MIP testing.	
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Spirometry:	<div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Refused <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Physically Unable <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Cognitively Unable <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Equipment Problem <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> Other → <input style="width: 30px;" type="checkbox"/> specify → <div style="border: 1px solid black; width: 400px; height: 20px; margin-left: 10px;"></div> </div>
MIP:	<div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Refused <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Physically Unable <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Cognitively Unable <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> Equipment Problem <input style="width: 30px;" type="checkbox"/> </div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> Other → <input style="width: 30px;" type="checkbox"/> specify → <div style="border: 1px solid black; width: 400px; height: 20px; margin-left: 10px;"></div> </div>