Interimhx

Date of visit

_____
(mm-dd-yyyy)

To be completed by Study Staff during interview with participant/parent/primary caregiver

Interview Questions

1. Date of prior visit/ history form:

_____
(mm-dd-yyyy)

Respondent identification

2. Who is the respondent (check all that apply):

- ☐ Participant
- ☐ Participant's mother
- ☐ Participant's father
- ☐ Participant's guardian (but not parent)
- ☐ Other

If other, specify:

_____

Demographic Information

Relationship of primary care giver to participant:

- ◯ Self
- ◯ Mother
- ◯ Father
- ◯ Niece or Nephew
- ◯ Aunt or Uncle
- ◯ First Cousin
- ◯ Second Cousin
- ◯ Grandparent
- ◯ Great Grandparent
- ◯ Great Great Grandparent
- ◯ Great Aunt or Great Uncle
- ◯ Great Great Aunt or Great Great Uncle
- ◯ Foster Parent
- ◯ Other
- ◯ Unrelated
- ◯ No answer

If other, specify:

_____

4. Is this the same respondent who completed the previous History form?

- ◯ Yes
- ◯ No

If No, Appendix A must also be completed at the end of interview.

5. Have there been any changes in demographic Information since the last visit? (ie: Marital status, Income, Type of Health Insurance, Number of people in home)

◯ Yes ◯ No

If Yes, Appendix A must be completed at the end of interview.

6. Have you moved since the last study visit?

◯ Yes
◯ No

6a. What is your current address (street block, city and zip only)?

_____

Chest Symptoms (ATS/DLD)

7. Does the participant usually have a cough with colds?

◯ Yes
◯ No
◯ No Colds Since Last Visit
◯ No answer

8. Does he/she usually have a cough without having a cold?

◯ Yes
◯ No

9. Did the participant cough on most days (4 or more days per week)?

◯ Yes
◯ No

10. How often has the participant had a cough, wheeze, shortness of breath or chest tightness during the past MONTH?

◯ 2 or fewer times per week ◯ daily ◯ 3-6 times per week ◯ continuously ◯ No answer

11. In the past MONTH, how often has the participant awakened from sleep because of coughing, wheezing, shortness of breath or chest tightness?

◯ 2 or fewer times per month ◯ 3-4 times per month ◯ 5-9 times per month ◯ 10 or more times per month ◯ No answer

12. In the past MONTH, how often has the participant had cough, wheeze, shortness of breath, or chest tightness while exercising or playing?

◯ 2 or fewer times per month ◯ 3-4 times per month ◯ 5-9 times per month ◯ 10 or more times per month ◯ No answer

13. Has the participant seemed congested in the chest or brought up phlegm(mucous) with colds?

◯ Yes
◯ No
◯ No Colds Since Last Visit
◯ No answer

14. Has he/she seemed congested in the chest or brought up phlegm(mucous) without having a cold?

◯ Yes
◯ No

15. Did he/she seem congested in the chest or bring up phlegm (mucous) from his/her chest on most days (4 or more days per week)?

◯ Yes ◯ No

16. Has the participant's chest sounded wheezy or whistling when he/she had a cold?

◯ Yes
◯ No
◯ No Colds Since Last Visit
◯ No answer

17. Did the participant's chest ever sound wheezy or whistling even when he/she did not have a cold?

◯ Yes
◯ No

18. Did the participant's chest sound wheezy or whistling most days or nights?

◯ Yes
◯ No

19. Has the participant had an attack of wheezing that has caused him/her to be short of breath?

◯ Yes
◯ No

19a. Has he/she had 2 or more such attacks?

◯ Yes
◯ No

19b. Has he/she required medicine or treatment for any of these attacks?

◯ Yes
◯ No

19c. Was his/her breathing completely normal between attacks?

◯ Yes
◯ No

20. Since the last visit, has the participant had an attack of any of the following after playing hard or exercising? (check all that apply)

☐ wheezing (whistling sound) ☐ coughing ☐ shortness of breath ☐ chest tightness
☐ none of the above

21. How often does respiratory symptoms (cough, wheezing, shortness of breath) keep the participant from doing what he/she wants to do?

◯ 2 or fewer times per month ◯ 3-4 times per month ◯ 5-9 times per month ◯ 10 or more times per month ◯ No answer

22. Think about all activities that the participant did during the past MONTH. How much was he/she bothered by respiratory symptoms (cough, wheeze, shortness of breath)?

◯ Not bothered at all ◯ hardly bothered ◯ bothered a little ◯ somewhat bothered
◯ quite bothered ◯ very bothered ◯ extremely bothered ◯ No answer

23. Since the last visit, has the participant been given a diagnosis of Asthma by a physician?

◯ Yes
◯ No

Respiratory (cough, wheeze, shortness of breath) and Atopy Symptoms

24. In the last 7 days:

24a. How many nights has the participant awakened because of respiratory symptoms?

_____
(nights)

24b. How many days has the participant had respiratory symptoms that interfered with his/her usual daily activity (e.g. school or work)?

_____
(days)

24c. How many days has the participant used albuterol (or other short-acting bronchodilator) because of respiratory symptoms?

_____
(days)

24d. How many days has the participant used albuterol (or other short-acting bronchodilator) for preventive use before exercise?

_____
(days)

25. Since the last visit, has the participant had any eczema?

◯ Yes
◯ No

26. In general, would you describe the participant's eczema as:

◯ Mild
◯ Moderate
◯ Severe
◯ No answer

27. Since the last visit, has the participant had problems with allergies?

◯ Yes
◯ No

28. In general, would you describe the participant's allergies as:

◯ Mild
◯ Moderate
◯ Severe
◯ No answer

Medications

29. Must fill out Interim History Medications Appendix for each medication participant is currently taking

30. Has the participant been prescribed oral steroids (e.g. prednisone, orapred) since the last visit?

◯ Yes ◯ No

30a. How many times?

_____

SLEEP SYMPTOMS OR PROBLEMS

31. During the past month, which of the following symptoms or problems has the participant had?

Current Nighttime Symptoms:

Snores	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Difficulty breathing while asleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Stops breathing during sleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Noisy breathing	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Restless sleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Sweating when sleeping	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer

Nightmares	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Sleep walking	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Sleep talking	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Screaming in his/her sleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Kicks or jerks legs in sleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Uncomfortable feelings in his/her legs; creepy/crawly before falling asleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Resists going to bed at bedtime	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer

Trouble falling asleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Feels like s/he can't move arms or legs when falling asleep	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Wakes up at night	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Gets out of bed at night	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Trouble staying in his/her bed at night	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Grinds his/her teeth	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Wets the bed	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer

32. If snoring or noisy breathing is present, how noisy has your child usually been in the past month?

◯ Does not apply ◯ Only slightly louder than heavy breathing ◯ About as loud as mumbling or talking
◯ Louder than talking ◯ Extremely loud - can be heard through a closed door ◯ Not sure
◯ No answer

33. Morning Waking and Daytime Symptoms

Noisy breathing	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Morning headaches	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Trouble getting out of bed in the morning	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Takes a long time to become alert in the morning	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Tardy for school or is missing school because of sleepiness	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Acts sleepy or seems overtired a lot	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer

Falls asleep in school	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Naps after school	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Gets weak in the knees or face with laughing or strong emotions	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Feels like s/he can't move arms or legs when waking up	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer
Has nighttime like dreams during the day when awake	◯ Never (does not happen) ◯ Not Often (< 1 night/day a week) ◯ Sometimes (1 to 2 nights/days a week) ◯ Often (3 to 5 nights/days a week) ◯ Always (6 to 7 nights/days a week) ◯ Don't Know ◯ No answer

34. During the past month, please describe the participant's sleep/wake schedule

School or Weekdays

Usual Bedtime

_____
(hh:mm (24 hour clock))

Time When Child Really Falls Asleep

_____
(hh:mm (24 hour clock))

Usual Wake Time

_____
(hh:mm (24 hour clock))

Non-School or Weekends

Usual Bedtime

_____
(hh:mm (24 hour clock))

Time When Child Really Falls Asleep

_____
(hh:mm (24 hour clock))

Usual Wake Time

_____
(hh:mm (24 hour clock))

Daily Napping

None

◯ Yes
◯ No

Number of naps

_____

Hours napping

_____

Smoking exposure

35. Since the last visit date, has the participant smoked cigarettes?

◯ Yes
◯ No

36. On average, how many days per week has participant smoked cigarettes?

_____
(days)

37. On the days participant smoked, about how many cigarettes did participant smoke per day?

_____
(cigarettes)

38. Since the last visit date has the participant smoked a pipe, or cigar smoke?

◯ Yes
◯ No

39. Since the last visit date, has the participant been exposed to second hand tobacco cigarette, pipe, or cigar smoke?

◯ Yes ◯ No

39a. On average, how many days per week has the participant been exposed to second hand cigarette, pipe, or cigar smoke?

_____
(days)

39b. On average, how many hours per day has the participant been exposed to second hand smoke?

_____
(hrs)

Additional Smoking Questions

40. Does the participant LIVE with anyone who currently smokes cigarettes? (not only the place where you live most of the time, but any other place where you also spend the night on a regular basis i.e. Grandparents' house, mom's house or dad's house, etc.)

◯ Yes ◯ No

41. In the past week, has the participant been in a car with someone who was smoking?	◯ Yes ◯ No
41a. How Frequently? (Choose one)	◯ Almost never ◯ Once a week ◯ Several times a week ◯ Everyday ◯ No answer
42. In the past week, has the participant been at someone else's house where someone was smoking?	◯ Yes ◯ No
42a. How frequently? (choose one)	◯ Almost never ◯ Once a week ◯ Several times a week ◯ Everyday ◯ No answer

43. In the past week, has the participant been inside a public place (i.e., a restaurant or club) where people were smoking?

◯ Yes ◯ No

43a. How frequently? (choose one)	◯ Almost never ◯ Once a week ◯ Several times a week ◯ Every day ◯ No answer
44. In the past week, has the participant spent time outside with people who were smoking?	◯ Yes ◯ No
44a. How frequently? (choose one)	◯ Almost never ◯ Once a week ◯ Several times a week ◯ Every day ◯ No answer
45. During the past week, did someone smoke in the participants' presence at work?	◯ Yes ◯ No
46. Do any of the participants' closest friends smoke cigarettes, cigars or pipes?	◯ Yes ◯ No
47. Has the participant been around anyone who smokes in the past 24 hours?	◯ Yes ◯ No

Headache questions

48. Does the participant have bad headaches or migranes?
- ◯ Yes
- ◯ No

If yes, Appendix B must be completed

49. Since the last visit date has the participant participated in any other medical research?
- ◯ Yes
- ◯ No

Appendix A

1. Head of household: What is the highest grade or level of school that you have completed or the highest degree that you have received?

◯ 1st ◯ 2nd ◯ 3rd ◯ 4th ◯ 5th ◯ 6th ◯ 7th ◯ 8th ◯ 9th ◯ 10th ◯ 11th
◯ 12th (no diploma) ◯ High School Graduate ◯ GED or equivalent ◯ Some college (no degree)
◯ Associate degree (occupational/technical degree) ◯ Associate degree (academic program)
◯ Bachelor's degree ◯ Master's degree ◯ Professional/doctoral degree ◯ Unknown
◯ Refused to Answer ◯ No answer

2. Marital status of primary care giver:
- ◯ Single
- ◯ Married
- ◯ Widowed
- ◯ Separated
- ◯ Divorced
- ◯ Unknown
- ◯ Living with partner
- ◯ Refused to answer
- ◯ No answer

3. Yearly family income
- ◯ < $10000
- ◯ $10000 to 19999
- ◯ $20000 to 29999
- ◯ $30000 to 39999
- ◯ $40000 to 49999
- ◯ $50000 to 59999
- ◯ $60000 to 69999
- ◯ $70000 to 79999
- ◯ $80000 to 89999
- ◯ $90000 to 99999
- ◯ $100000 to 149999
- ◯ >$150000
- ◯ Refused to answer
- ◯ Unknown
- ◯ No answer

4. Number of people in home age 17 or older: _____

5. Number of people in home less than 17 years of age: _____

6. Type of health insurance (check all that apply):
- ☐ Government Health Services (non USA sites)
- ☐ Medicaid
- ☐ Private
- ☐ None

Appendix B

Chronic (recurring headaches)

1. Does the participant have recurring headaches?	◯ Yes ◯ No
1a. How often (choose one)?	◯ < 1 month ◯ 1-4 per month ◯ >=1 per week ◯ No answer
2. How long have headaches been present (choose one)?	◯ < 6 months ◯ 6-12 months ◯ 1-2 years ◯ >2 years ◯ No answer
3. Where is the headache typically located (choose one)?	◯ Bifrontal or bitemporal ◯ Right hemicranial ◯ Left hemicranial ◯ Vertex ◯ Occipital ◯ Nonlocalized ◯ diffuse ◯ No answer
4. Duration of typical headache (choose one)?	◯ < 10 minutes ◯ 10-59 minutes ◯ 1-6 hours ◯ >6 hours ◯ No answer
5. When does the headache most often occur (choose one)?	◯ During daytime at school ◯ During afternoon/evening after coming home from school ◯ Late evening or bed time ◯ No particular time ◯ No answer
6. Severity of typical headache (choose one)?	◯ No interruption of normal life activities ◯ Some disruption of normal life activities but no need to go to bed ◯ Complete disruption of normal life activities ◯ Prevents sleep or requires patient to ◯ be examined by physician ◯ Awakens patient from sleep ◯ No answer
7. Other symptoms associated with some or most headaches? Check all that apply:	
7. Other symptoms associated with some or most headaches? Check all that apply:	☐ Nausea or vomiting ☐ excessive sensitivity to light or sound ☐ fatigue, malaise ☐ sleep apnea ☐ excessive daytime sleep ☐ visual symptons ☐ Other

If so, Specify:	_____
If so, specify:	_____
8. Is medication taken for most headaches?	◯ Yes ◯ No
8a. Does the participant take abortive or rescue medication?	◯ Yes ◯ No
8b. Specify type:	_____
8c. How effective is it (choose one)?	◯ Partial improvement most occasions ◯ Complete remission most occasions ◯ Little or no improvement most occasions ◯ No answer
8d. Does the participant take daily preventative medication?	◯ Yes ◯ No
8d. Specify type:	_____
9. Are there other family members with a history of recurrent headaches?	◯ No ◯ Yes ◯ Don't Know ◯ No answer
9a. If Yes, have they been given the diagnosis of migraines?	◯ No ◯ Yes ◯ Don't Know ◯ No answer
10. Has the participant ever experienced a seizure?	◯ No ◯ Yes ◯ Don't Know ◯ No answer
10a. If Yes, was the seizure associated with (check all that apply):	
10a. If Yes, was the seizure associated with (check all that apply):	☐ Fever ☐ Pain Crisis ☐ Don't know
11. Have other family members had seizures?	◯ No ◯ Yes ◯ Don't Know ◯ No answer
11a. If Yes, relationship to patient:	_____

12. Has the participant ever had a diagnosis of a silent stroke?

◯ No
◯ Yes
◯ Don't Know
◯ No answer

12a. If Yes, reason for MRI (check all that apply):

12a. If Yes, reason for MRI (check all that apply):

☐ Routine care or surveillance
☐ Suspected Stroke
☐ Recurrent headaches
☐ Headache
☐ Seizure
☐ Abnormal TCD

12b. If Yes, year of diagnosis of silent stroke

_____

13. Has the participant ever had a very severe headache preventing participation in normal activities, or leading to a doctor or emergency room visit?

◯ Yes ◯ No

13a. Is the participant confused or difficult to wake up during headache?

◯ Never
◯ Once in a While
◯ With most headaches
◯ No answer

13b.The participant complain of a stiff neck or neck pain during headache?

◯ Never
◯ Once in a While
◯ With most headaches
◯ No answer

13c.The participant has a neurological symptom during or after a headache?

◯ Never
◯ Once in a while
◯ With Most headaches
◯ No answer

13d. What neurological symptoms (check all that apply)?:

13d. What neurological symptoms (check all that apply)?:

☐ Became dizzy((as if the room were spinning)
☐ Could not speak or comprehend what was spoken
☐ Paralysis or inability to move one side of the body or part of the body
☐ Could not see
☐ Unsteady gait

Other? Specify:

_____

14. Is the participant awakened in the middle of the night by a headache which was not present at bed time?

◯ Never ◯ Once in a while ◯ With most headaches ◯ No answer

Acute Headache Questions

15. Does the participant have a headache now or at any time during the past 7 days?	◯ Yes ◯ No
If no, form is complete.	
15a. Has she/he had similar headaches before?	◯ Yes ◯ No
15b. How does the participant describe the headache(check one)?	◯ mild ◯ not interfering with activity ◯ moderate ◯ interfering with activity ◯ severe ◯ unable to function ◯ other ◯ No answer
If other, describe:	_____
15c.Did or does the participant have a fever or other symptoms with headache?	◯ Yes ◯ No
15d. Describe other symptoms:	_____
16. Has the particpant been started on chronic blood transfusion therapy since the last study visit?	◯ Yes ◯ No
17. If yes, give date of last transfusion.	_____ (ddMMyyyy)