



Alpha 1 Canadian Registry

399 Bathurst Street, 7E Rm 445
Toronto, ON M5T 2S8
Phone: 1-800-352-8186 Fax: 416-603-5020

Registry ID # _____

Completed By: _____ Signature: _____ Date(d/m/y): _____

*PLEASE FILL OUT THIS FORM, SIGN, and MAIL IT BACK TO US

Baseline Information

Registry ID # _____ Patient's Name _____ Sex: M F

Birthdate (d/m/y) _____ Height (cm) _____ Weight (kg) _____

Smoking History: Ever smoked? YES / NO If yes, CURRENT / EX-SMOKER
Age Started: _____ Age Stopped: _____
Average Number of Cigarettes: _____ Cigars: _____ Pipes: _____

Reason for Alpha-1 Antitrypsin Analysis:

- Lung Disease
- Liver Disease
- Family Screening
- Population Screening
- Other diseases
- Other: _____

Phenotype of Alpha-1 PI deficiency: (please include a copy of the test results)

Date of Diagnosis (dd/mm/yy): _____ Alpha 1 Anti-trypsin Level: _____ (units)
 ZZ SZ Other (specify): _____

Medical History:

Lung Disease: No Yes If YES to lung disease, please check type below:

- Chronic Bronchitis Emphysema Asthma
- Bronchiectasis Other (specify): _____

Age at onset of respiratory symptoms: Years _____ Months _____

Main respiratory symptom present: non-productive cough
(Check only one) Productive cough
Dyspnea at rest
Dyspnea on exertion
Attacks of dyspnea

Other relevant medical diagnoses (including liver): No Yes If YES, please specify below:



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Medical History (continued):

Lung Transplantation: No Yes Date: (dd/mm/yy) ___/___/___
 Lung Volume Reduction: No Yes Date: (dd/mm/yy) ___/___/___
 Liver Transplantation: No Yes Date: (dd/mm/yy) ___/___/___

Has the patient Ever had Pneumonia: No Yes, # times: ___ Unknown

CT-data:

Is any CT-scan of the Thorax available: No Yes Date: (dd/mm/yy) ___/___/___

Treatment:

Medication for Lung Disease: No Yes
 Long-term oxygen treatment: No Yes

Has the patient ever been treated by Alpha-1 Pi Augmentation Therapy?

No Yes Date:(dd/mm/yy) ___/___/___

Has the patient stopped treatment?

No Yes Date:(dd/mm/yy) ___/___/___

Lung Function Testing: Please attach copies

Date of First available Lung Function: (dd/mm/yy) ___/___/___

Pre Bronchodilator

FEV1 _____ L
 FVC _____ L
 SVC _____ L
 Kco (DLCO/VA) _____ L

Post Bronchodilator

FEV1 _____ L
 FVC _____ L
 SVC _____ L

Date of Most Recent Lung Function: (dd/mm/yy) ___/___/___

Pre Bronchodilator

FEV1 _____ L
 FVC _____ L
 SVC _____ L
 Kco (DLCO/VA) _____ L

Post Bronchodilator

FEV1 _____ L
 FVC _____ L
 SVC _____ L



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Liver Enzymes: No Yes Date:(dd/mm/yy) ___/___/___ (please attach results)

Abnormalities

ALAT/SGOT No Yes Not Done

ASAT/SGPT No Yes Not Done

GT No Yes Not Done

ALP/AP No Yes Not Done

Occupational Status:

Regularly working No

Yes

If **NO**, specify reason: Age

Liver disease

Lung Disease

Other

**Thank you for taking the time to complete this information, if you have any questions, **
please contact the toll-free number