# COPD Assessment Form

P.O. Box 153178, Tampa, FL 33684

**Health and Wellness Material**

Date of Birth:

Phone#:

Date:

Member Name:

Member Address:

City State Zip:

ID#:

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? ❑ Yes ❑ No

**If you received this form in error and don't have this health, check the box and return the form to us in the supplied envelope without answering any of the questions below.** ❑ **No, I don't have COPD.**

**1. How often do you experience shortness of breath?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**2. Do you have an ongoing cough?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**3. Has the doctor ordered Oxygen for you to use at home?** ❑ Yes ❑ No

**4. If you answered yes to question #3, how often do you use your Oxygen?**
(check one) ❑ Never ❑ Occasionally ❑ During the day ❑ All the time

**5. If you answered yes to question #3, do you use oxygen as ordered by your doctor?** ❑ Yes ❑ No

**6. If you answered yes to question #5, how many liters of Oxygen do you use?**
(check one) ❑ 0 liters ❑ 1-2 liters ❑ 3-4 liters ❑ More than 4 liters

**7. Do you use a hand-held nebulizer at home?** ❑ Yes ❑ No

**8. Do you use different breathing methods (ex. pursed-lips) when short of breath or anxious?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**9. How many inhalers do you use?**
(check one) ❑ 1 inhaler ❑ 2-3 inhalers ❑ More than 3 inhalers ❑ Don't use an inhaler

**10. Do you take any of the following oral medications for your Chronic Obstructive Pulmonary Disorder (COPD)?**
(check one) ❑ Montelukast/Singulair ❑ Prednisone/Steroids (every day) ❑ Theophylline ❑ None

**11. Do you smoke?** ❑ Yes ❑ No

**12. Does anyone in your household smoke?** ❑ Yes ❑ No

**13. How many times in the past year have you seen your doctor for your COPD?**
(check one) ❑ 0 ❑ 1-2 times ❑ 3-4 times ❑ More than 4 times

# COPD Assessment Form *(continued)*

**14. How many times in the past year have you been to the Emergency Room due to your COPD?**
(check one) ❑ 0 ❑ 1-2 times ❑ 3-4 times ❑ More than 4 times

**15. How many times in the past year have you been hospitalized due to your COPD?**
(check one) ❑ 0 ❑ 1-2 times ❑ 3-4 times ❑ More than 4 times

**16. Does your COPD prevent you from enjoying your life?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**17. Does your COPD prevent you from getting a good night's sleep?**
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

**18. Have your eating habits changed over the last year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**19. Do you think your COPD has become better or worse over the past year?**
(check one) ❑ Better ❑ Worse ❑ Stayed the same

**20. How would you rate your ability to take care of yourself with the support you have in place?**
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor