P.O. Box 153178, Tampa, FL 33684

Health and Wellness Material

COPD Assessment Form

Date: ________________

Name: ______________________________________

Address: ____________________________________

City:________________ State:______ Zip: _________

DOB:_____________ Age: _____ Gender: ____

Phone number: ___________________________

Member 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 condition, 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 ❑ Only at night ❑ 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) ❑ 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 use tobacco (smoke, chew, snuff, vape or in any other form)? ❑ Yes ❑ No

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COPD Assessment Form *(continued)*

11. Does anyone in your household smoke/vape? ❑ Yes ❑ No

12. 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

13. 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

14. 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

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

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

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

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

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

20. What is your living situation today? (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

21. Within the past 12 months, have you worried that your food would run out before you got money to buy more?
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

22. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No