

**COPD Assessment Form**

P.O. Box 153178, Tampa, FL 33684
Health and Wellness Material

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.

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|--|
| 1. How often do you experience shortness of breath? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always |
| 2. Do you have an ongoing cough? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always |
| 3. Has the doctor ordered Oxygen for you to use at home? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. If you answered yes to question #3, how often do you use your Oxygen? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> During the day <input type="checkbox"/> Only at night <input type="checkbox"/> All the time |
| 5. If you answered yes to question #3, do you use oxygen as ordered by your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. If you answered yes to question #5, how many liters of Oxygen do you use? (check one) <input type="checkbox"/> 1-2 liters <input type="checkbox"/> 3-4 liters <input type="checkbox"/> More than 4 liters |
| 7. Do you use a hand-held nebulizer at home? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you use different breathing methods (ex. pursed-lips) when short of breath or anxious? (check one) <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Very Often <input type="checkbox"/> Always |
| 9. How many inhalers do you use? (check one) <input type="checkbox"/> 1 inhaler <input type="checkbox"/> 2-3 inhalers <input type="checkbox"/> More than 3 inhalers <input type="checkbox"/> Don't use an inhaler |
| 10. Do you use tobacco (smoke, chew, snuff, vape or in any other form)? <input type="checkbox"/> Yes <input type="checkbox"/> No |

H5594_2024_DSHAT_COPD_C

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