



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

COPD Assessment Form

Date:

Date of Birth:

Member Name:

Phone#:

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 disease, 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) <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"/> 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"/> 0 liters <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 take any of the following oral medications for your Chronic Obstructive Pulmonary Disorder (COPD)? (check one) <input type="checkbox"/> Montelukast/Singulair <input type="checkbox"/> Prednisone/Steroids (every day) <input type="checkbox"/> Theophylline <input type="checkbox"/> None
11. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Does anyone in your household smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. How many times in the past year have you seen your doctor for your COPD? (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> 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