NAME: Date of Birth:

COPD REVIEW

|  |  |
| --- | --- |
| Height |  |
| Weight |  |
| Blood Pressure |  |

# Review

This questionnaire is for a routine review of your COPD symptoms, please complete this ahead of your appointment and bring it with you, or return it ahead of time. If you have not already booked your review, please do so by calling 01425 478901.

# COPD Review

**Coughing:** Please select the best description of your cough

|  |  |  |
| --- | --- | --- |
| No cough | Dry cough | Productive cough: Clear sputum |
| Productive cough: Green sputum | Productive cough: Yellow sputum | Sputum Appearance: Frothy/Watery |
| Unable to cough up sputum |  |

**Night Symptoms:** Please select the best description of your night symptoms

|  |  |  |
| --- | --- | --- |
| No cough | Cough | Cough and wheeze |
| Difficulty breathing: Breathlessness/shortness ofbreath |  |

**Breathing at Night:** Please select the best description of your breathing at night

|  |  |  |
| --- | --- | --- |
| No breathlessness (normal breathing) | Breathlessness when lying flat | Severe breathlessness that wakes you up |

**Swelling/Oedema:** Please select any symptoms of swelling (oedema) that apply to you

|  |  |  |
| --- | --- | --- |
| No swelling | Sweeling of feet only | Sweeling up to ankles |
| Swelling up to legs | Swelling up to thighs |  |

**Breathing:** Please select the best description of your breathing

|  |  |  |
| --- | --- | --- |
| I am short of breath only on strenuous exercise | I am short of breath when hurrying or walking up a slight hill | I walk slower than my peers on level ground due to breathlessness, or stop ifwalking at my own pace. |
| I stop for breath after walking 100 yards, or after a few minutes walking on level ground | I am breathless when dressing or I am too breathless to leave the house |  |

|  |
| --- |
| **Exacerbations:** How many COPD exacerbations (attacks) have you had in the past year? |
|  |
| **Hospital Admissions:** How many hospital admissions have you had due to COPD in the past year? |

# Inhaler Technique

It is essential to have good inhaler technique to ensure that your medication gets to the part of your lungs that need it. If possible, please visit [www.copdfoundation.org/Learn-More/Educational-Materials-Resources/Educational-Video-](http://www.copdfoundation.org/Learn-More/Educational-Materials-Resources/Educational-Video-Series.aspx) [Series.aspx](http://www.copdfoundation.org/Learn-More/Educational-Materials-Resources/Educational-Video-Series.aspx) and watch the specific inhaler video to ensure you are using your inhalers correctly.

I have watched the relevant video and I am happy with my inhaler technique:

|  |  |  |
| --- | --- | --- |
| Yes | No | I would like to discuss my inhaler technique at myappointment |

# Further Questions

I have the following questions that I would like to raise with my COPD Nurse or Doctor

# Lifestyle: Alcohol

How often do you have a drink containing alcohol?

|  |  |  |
| --- | --- | --- |
| Never | Monthly or less | 2-4 times a month |
| 2-3 times a week | 4 times a week or more |  |

How many units of alcohol do you consume on a typical day drinking?

|  |  |  |
| --- | --- | --- |
| 1-2 | 3-4 | 5-6 |
| 7-9 | 10+ |  |

How often have you, as a woman, had 6 or more units or, as a man, had 8 or more units in a single occasion in the last year?

|  |  |  |
| --- | --- | --- |
| Never | Less than monthly | Monthly |
| Weekly | Daily, or almost daily |  |

# Lifestyle: Smoking

|  |
| --- |
| Do you smoke? |
| Never smoked | Ex-smoker | Trivial smoker (less than 1 cigarette per day) |
| Light smoker (1-9 cigarettes per day) | Moderate smoker (10-19 cigarettes per day) | Heavy smoker (20-39 cigarettes per day) |
| Very heavy smoker (40 or more cigarettes per day) |  |

|  |
| --- |
| Do you use an e-cigarette? |
| No | Ex-user | Yes |

|  |
| --- |
| If you do you smoke, would you like help to quit smoking? |
| Yes | No |

Giving up smoking is the best thing you can do for your health and you’re up to four times more likely to give up with help from your local stop smoking service. An online secure referral form can be found at [www.smokefreehampshire.com,](http://www.smokefreehampshire.com/) you can email smokefree.hampshire@nhs.net or telephone 01264 563039 / 0800 772

3649

# COPD Assessment Test Score

The COPD Assessment Test provides a score to help you and your healthcare provider determine if your COPD symptoms are well controlled

Please select a score of 0 to 5 to help assess the severity of your symptoms.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Coughing** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| I never cough |  |  |  |  |  |  | I cough all the time |
|  |
| **Phlegm** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| I have no phlegm (mucus) on my chestat all |  |  |  |  |  |  | My chest is full of phlegm(mucus) |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Chest** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| My chest does not fell tight at all |  |  |  |  |  |  | My chest feels very tight |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Breathlessness** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| When I walk up a flight of stairs or a hill I am not out of breath |  |  |  |  |  |  | When I walk up a flight of stairs or a hill I am completely outof breath |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Activities** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| I am not limited to doing any activities at home |  |  |  |  |  |  | I am completely limited to doing activities athome |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Confidence** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| I am confident leaving my house despite my lung condition |  |  |  |  |  |  | I am not confident leaving myhouse |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Sleep** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| I sleep soundly |  |  |  |  |  |  | I do not sleepsoundly |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Energy** | 0 | 1 | 2 | 3 | 4 | 5 |  |
| I have lots of energy |  |  |  |  |  |  | I have no energy at all |

|  |  |
| --- | --- |
| **Score:** |  |
| Very High: | If your score is >30. | There is significant room for improvement in your COPD management |
| High: | If your score is 20-30. | There is room for improvement in your COPD management |
| Medium: | If your score is 10-20. | There is room for optimisation in your COPD management |
| Low: | If your score is <10. | Your COPD is well managed. |

Your answers will always be seen by one of the practice team who will be in touch, if necessary.