SALISBURY MEDICAL PRACTICE

Help us to manage your COPD - Take the COPD Assessment Test

Name: *Please print*		Date of birth:	

For each item below, please tick the number scale that best describes you currently; 0 being no impact and 5 being maximum impact
(Please only select one response for each)

I never cough	0	1	2	3	4	5	I cough all the time
I have no phlegm (mucus) in my chest at all	0	1	2	3	4	5	My chest is completely full of phlegm
My chest does not feel tight at all	0	1	2	3	4	5	My chest feels very tight
When I walk up a hill or one flight of stairs I am not breathless	0	1	2	3	4	5	When I walk up a hill or one flight of stairs I am very breathless
I am not limited doing any activities at home	0	1	2	3	4	5	I am very limited doing activities at home
I am confident leaving my home despite my lung condition	0	1	2	3	4	5	I am not at all confident leaving my home because of my lung condition
I sleep soundly	0	1	2	3	4	5	I don't sleep soundly because of my lung condition
I have lots of energy	0	1	2	3	4	5	I have no energy at all

Which statement best applies to you? (Please tick one option)	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 contemporaries on level ground	
	I stop for breath after walking 100 yards on level ground	
	I am breathless if dressing or too breathless to leave the house	

Are you a smoker?	Yes		Ex-smoker			
	Use a vape		Never smoked			
Would you like help to stop smoking?			Yes		No	

Please tick this box if you are happy for us to contact you regarding your responses				
Preferred contact number				
Do you consent contact by an SMS message?	Yes		No	

For admin purposes - please initial here when completed to patient notes: