**COPD Pre-visit Worksheet** **Name:** **Date:**

**This worksheet will help you get ready for your visit to talk to a doctor about your COPD.**

**When were you diagnosed with COPD?** Age: _____ years **Not Diagnosed:** ☐

## Do you (circle or check yes or no and add details):

Feel like you can do the things that you want? ☐ Yes ☐ No

Feel like you have enough energy? ☐ Yes ☐ No

Miss work for breathing issues? ☐ Yes ☐ No # Days _____ per month/ year

Wake up because of your breathing? ☐ Yes ☐ No #Nights_____per week

Have feelings of shortness of breath? ☐ Yes ☐ No ☐ Every day OR # days per week _____

How many flights of stairs are you able to walk? # Flights _____

Does your chest feel tight? ☐ Not at all ☐ A little bit ☐ A lot ☐ Very tight

Do you ever feel short of breath when you lay flat? ☐ Yes ☐ No

Have a cough that has been around for more than 6 months? ☐ Yes ☐ No ☐ Every day OR # days per week_____

Does your cough bring up mucus? ☐ Yes ☐ No

What does it look like? ☐ thick ☐ yellow ☐ green ☐ other: _____

How often do you have a productive cough? ☐ Every day OR # days per week _____

Do you get a lot of respiratory infections? ☐ Yes ☐ No # in past year: _____

## Have you (circle or check yes or no and add details):

Ever gone to the Emergency Room for breathing issues? ☐ Yes ☐ No # in past year_____ # lifetime_____

Been hospitalized for COPD? ☐ Yes ☐ No # _____ past year/ lifetime_____

Been hospitalized in the ICU because of COPD? ☐ Yes ☐ No # _____lifetime

Had to be Intubated (tube down throat to help breathe)? ☐ Yes ☐ No # times in lifetime_____

Taken oral steroids pills (prednisone) or shots in the past year? ☐ Yes ☐ No #_____

Had a test called Pulmonary Function Test or spirometry? ☐ Yes ☐ No Date: _____

Been told that you have (circle all that apply): ☐ heart disease ☐ stroke ☐ seasonal allergies ☐ asthma

## Exposure to things that might have made your breathing worse:

Have you ever smoked, vaped or used e-cigarettes? ☐ Yes ☐ No # /day_____for # years_____

What have you smoked or vaped? ☐ Tobacco ☐ Marijuana ☐ Flavors

Do you smoke, vape or use e-cigarettes now? ☐ Yes ☐ No # /day_____for # years_____

What do you smoke or vape? ☐ Tobacco ☐ Marijuana ☐ Flavors

Exposed to smoke inside your home? ☐ Yes ☐ No

Exposed to chemicals or gases at work? ☐ Yes ☐ No ☐ Type of work: _____

Other exposures that you feel have made your breathing bad: _____

**Have you noticed anything in your environment that makes your breathing worse? (circle or check all that apply)**

☐ Smoke ☐ Pets ☐ Colds/respiratory infections ☐ Pollen ☐ Mold/mildew ☐ Cockroaches

☐ Emotions ☐ Stress ☐ Strong chemicals ☐ Dust ☐ Changes in weather

☐ Being active outside ☐ Air Pollution ☐ Breathing cold air

☐ Other: _____ ☐ Exercise (type)_____

**Which months are the worst for your breathing? (circle or check all that apply)**

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

## What you know about COPD:

Do you feel like your COPD has been well controlled? ☐ Yes ☐ No

Do you feel that you understand how the lungs work and how they are different with COPD? ☐ Yes ☐ No

Do you feel that you know what things make your COPD worse? ☐ Yes ☐ No

Do you feel like you take your medications correctly? ☐ Yes ☐ No

Do you ever miss any of your medication doses? If yes, how many days a week? _____ ☐ Yes ☐ No

Do you feel like you know what to do when your COPD symptoms get worse? ☐ Yes ☐ No

Have you ever had a COPD action plan? ☐ Yes ☐ No

### What medication have you taken in the past for breathing issues?

| Medication Name | Medication Dose | How often taken | Why was it stopped? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## What medications are you currently taking for breathing issues?

| Medication Name | Medication Dose | How often taken | Is this medicine a controller or reliever medicine? (circle) |
|---|---|---|---|
| | | | Controller ☐ Reliever ☐ |
| | | | Controller ☐ Reliever ☐ |
| | | | Controller ☐ Reliever ☐ |
| | | | Controller ☐ Reliever ☐ |
| | | | Controller ☐ Reliever ☐ |

If you have been taking inhalers (puffers), do you use a chamber/spacer? ☐ Yes ☐ No

How often do you take your reliever medication (albuterol, ProAir, Ventolin, Atrovent, Combivent)? #/week_____

## What are your goals for your COPD?

☐ Less workdays missed ☐ Sleep through the night ☐ Able to play sports or exercise

☐ Able to be active outside ☐ No hospitalizations ☐ Feel like my COPD is under control

☐ **Other:**_____

☐ **Other:** _____

## Do you have anything else that you would like to talk to your doctor about?