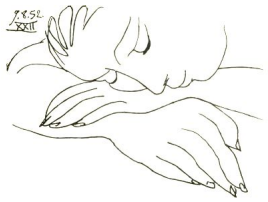
Pulmonary and Sleep Associates of Marin



100 Rowland Way, Suite 300
Novato, CA 94945

Phone: 415-878-0225
Fax: 415-878-0215
MarinPulmonarySleep.com

PULMONARY PATIENT FOLLOW-UP QUESTIONNAIRE

Name: _____ **Date:** _____
Date of Birth: _____

Please list any new medications or changes in your medical history (including diagnoses, hospitalizations, or surgeries) since your last visit:

_____

In the past 2 weeks, have you had any of the following symptoms (Circle if applies):

Weight Change	Confusion	Nasal Congestion	Leg swelling
Loss of Appetite	Memory Problems	Sinus pressure/pain	Heartburn/Reflux
Fevers/Chills/Sweats	Joint/Muscle Pain	Cough	Abdominal Pain
Vision Change	Incoordination/Falls	Shortness of Breath	Nausea/Vomiting
Headaches	Numbness/Tingling	Wheezing	Urinary Problems
Dizziness	Muscle weakness	Chest Pain	Rashes
Tremor	Anxiety/Depression	Palpitations	Other? _____

For patients with chronic lung disease:
*circle your level of breathlessness in the past **4 weeks**...*
(CIRCLE ONE)

Grade	Description of Breathlessness
0	I only get breathless with strenuous exercise.
1	I get short of breath when hurrying on level ground or walking up a slight hill.
2	On level ground, I walk slower than people of the same age because of breathlessness, or have to stop for breath when walking at my own pace.
3	I stop for breath after walking about 100 yards or after a few minutes on level ground.
4	I am too breathless to leave the house or I am breathless when dressing.

Epworth Sleepiness Scale: *Choose the most appropriate number for each situation*:
0 – no chance of dozing
1 – slight chance of dozing
2 – moderate chance of dozing
3 – high chance of dozing

SITUATION	**0-3**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e., theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

Your name:

Today's date:

How is your COPD? Take the COPD Assessment Test (CAT)

This questionnaire will help you and your healthcare professional measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on your wellbeing and daily life. Your answers, and test score, can be used by you and your healthcare professional to help improve the management of your COPD and get the greatest benefit from treatment.

For each item below, place a mark (X) in the box that best describes you currently. Be sure to only select one response for each question.

Example: I am very happy 0 X 2 3 4 5 I am very sad

			SCORE
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 (mucus)**	
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**	
		TOTAL SCORE	

Asthma Control Test®

This survey was designed to help you describe your asthma and how your asthma affects how you feel and what you are able to do. To complete it, please mark an X in the box that best describes your answer.

1. In the **past 4 weeks**, how much of the time did your asthma keep you from getting as much done at work or at home?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. During the **past 4 weeks**, how often have you had shortness of breath?

More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. In the **past 4 weeks**, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	2 to 3 nights a week	Once a week	Once or twice	Not at all
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

4. In the **past 4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as Albuterol, Ventolin®, Proventil®, Maxair®, or Primatene Mist®)?

3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. How would you rate your asthma control during the **past 4 weeks**?

Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completey controlled
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Total Score

If your score is 19 or less,
your asthma may not be under control.

☐