COPD STEP BY STEP

Keep the conversation flowing with your doctor.

Simply complete the form below and bring
it with you to your next appointment.

Since your last doctor's appointment, have you:
(check all that apply)

- [ ] experienced changes in your cough?

- [ ] experienced changes in your mucus/phlegm (amount, consistency, or color)?

- [ ] experienced changes in your breathing (shortness of breath or difficulty breathing)?

- [ ] had a flare-up or worsening of COPD symptoms more than typical day-to-day variations?

- [ ] felt more tired than usual or been waking up at night?

- [ ] been unable to get as much done at work, home, or school?

- [ ] used an antibiotic or oral steroid? If yes, number of days taken: _____

- [ ] had a severe cold or flu?

- [ ] visited an ER, hospital, or urgent care because of your breathing?

- [ ] used a rescue inhaler more or less than usual? If yes, number of times per week: _____

- [ ] smoked more, smoked less, or set a plan to stop smoking?

- [ ] stopped smoking completely?

Which of the following best describes your breathing lately?
(check all that apply)

- [ ] I am short of breath after moderate exercise.

- [ ] I am short of breath when hurrying or walking up a slight incline.

- [ ] I walk slower than most people my age due to my breathing.

- [ ] I stop for breath every few minutes while walking, even on level ground.

- [ ] I am too short of breath to leave the house.

List any activities you have missed or limited due to breathing difficulties:

_____

_____

_____

Describe how well you are managing your current COPD medication routine:

Do you take your medication(s) exactly as prescribed? Do you take it/them on time?

_____

_____

_____

Are there any COPD treatment options you want to ask your doctor about?

_____

_____

_____

What medical information have you received from other healthcare providers?

Do you have other health conditions? Did you have any diagnostic or lab tests?

If so, what were the results? Were you prescribed any other medications?

_____

_____

_____

List all medications you are currently taking, including prescription medicines,

vitamins, supplements, herbal and non-prescription OTC products:

_____

_____

_____