

■ N/A

☐ N/A

Client Name (please print)	
Client Identifier Type e.g. Jurisdictional Health Number	Client Identifier Assigning Authority e.g. OHIP

□ N/A

COPD Diagnosis*	N/A
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☐ N/A

Client Name <input style="width: 250px;" type="text"/>		Jurisdictional Health Number <input style="width: 200px;" type="text"/>																																																																														
Family History of Lung Disease <input type="checkbox"/> N/A		Current Symptoms <input type="checkbox"/> N/A																																																																														
Family History of COPD, Allergy and/or Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes select conditions from a list and indicate which relative) COPD <input type="checkbox"/> Parent <input type="checkbox"/> Sibling Allergy <input type="checkbox"/> Parent <input type="checkbox"/> Sibling Alpha-1 Antitrypsin <input type="checkbox"/> Parent <input type="checkbox"/> Sibling Asthma <input type="checkbox"/> Parent <input type="checkbox"/> Sibling		Breathlessness <input type="checkbox"/> at rest <input type="checkbox"/> on exertion Chest tightness <input type="checkbox"/> Yes <input type="checkbox"/> No Wheeze <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> Sputum production <input type="checkbox"/> <input type="checkbox"/> Sputum colour _____ Sputum consistency _____ Sputum volume _____ Hemoptysis* <input type="checkbox"/> <input type="checkbox"/> Frequent colds <input type="checkbox"/> <input type="checkbox"/> If yes frequency <input type="checkbox"/> 0-3/year <input type="checkbox"/> 4-7/year <input type="checkbox"/> ≥8/year Colds that last longer than 7 days <input type="checkbox"/> <input type="checkbox"/> Symptoms worse at night (including cough) <input type="checkbox"/> <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> Limitation of activities at home <input type="checkbox"/> <input type="checkbox"/> Sleep soundly <input type="checkbox"/> <input type="checkbox"/> Decreased energy level <input type="checkbox"/> <input type="checkbox"/> *This symptom must be reported to the client's provider																																																																														
Physical Exam <input type="checkbox"/> N/A																																																																																
<input type="checkbox"/> Normal breath sounds <input type="checkbox"/> Abnormal breath sounds If abnormal, select auscultatory finding <input type="checkbox"/> Wheezes <input type="checkbox"/> Crackles <input type="checkbox"/> Reduced Breath Sounds <input type="checkbox"/> Bronchial (harsh and prolonged inspiration and expiration) <input type="checkbox"/> Barrel chested <input type="checkbox"/> Clubbing <input type="checkbox"/> Cachectic Vitals: HR _____ RR _____ BP _____																																																																																
Smoking <input type="checkbox"/> N/A																																																																																
Smoking Status <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> Smoker (# of cigarettes per day ____) Quit Date <input style="width: 80px;" type="text" value="YYYY/MM/DD"/> Quit Duration When was the last time you smoked a cigarette, even a puff? <input type="checkbox"/> > 6 months <input type="checkbox"/> 1-6 months <input type="checkbox"/> < 1 month Passive Smoking Risk <input type="checkbox"/> Yes <input type="checkbox"/> No		Smoking Cessation Quit Intentions Are you planning to quit smoking? <input type="checkbox"/> within a month <input type="checkbox"/> within 6 months <input type="checkbox"/> beyond 6 months <input type="checkbox"/> not planning to quit Stages of Change Addressed <input type="checkbox"/> pre-contemplation <input type="checkbox"/> contemplation <input type="checkbox"/> preparation <input type="checkbox"/> action <input type="checkbox"/> maintenance Smoking Cessation Addressed <input type="checkbox"/> Ask <input type="checkbox"/> Advise <input type="checkbox"/> Arrange Smoking Cessation Aids <input type="checkbox"/> Nicotine Replacement Therapy (NRT) <input type="checkbox"/> Prescription medication (e.g., varenicline, bupropion)																																																																														
Pack Years Cig Smoked/day <input style="width: 40px;" type="text"/> /20 x Years smoked <input style="width: 40px;" type="text"/> = Pack years <input style="width: 40px;" type="text"/> Smoke Type <input type="checkbox"/> non-traditional tobacco (e.g. cigarettes/ cigarillo/ cigar) <input type="checkbox"/> Cannabis use <input type="checkbox"/> e-cigarette user <input type="checkbox"/> traditional tobacco (e.g. smudging ceremonies) <input type="checkbox"/> Inhalation vapor user <input type="checkbox"/> hooka <input type="checkbox"/> shisha																																																																																
COPD Healthcare Utilization <input type="checkbox"/> N/A		Barriers <input type="checkbox"/> N/A																																																																														
Visit(s) to primary care physician in the last 12 months for COPD symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, indicate the number of primary care visits for COPD in the last 12 months Routine primary care visits <input style="width: 40px;" type="text"/> Urgent primary care visits <input style="width: 40px;" type="text"/> Visit(s) to a specialist for COPD <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Unknown</th> <th>Last 12 Months</th> </tr> </thead> <tbody> <tr> <td>Respirologist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>General Internist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Allergist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Unknown</th> <th>Recent < 1yr</th> <th>Total # ever</th> </tr> </thead> <tbody> <tr> <td>ED visits since last visit</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 40px;" type="text"/></td> </tr> <tr> <td>Hospitalized since last visit</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 40px;" type="text"/></td> </tr> <tr> <td>ICU admissions since last visit</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 40px;" type="text"/></td> <td><input style="width: 40px;" type="text"/></td> </tr> <tr> <td>Systemic steroid use since last visit</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input style="width: 40px;" type="text"/></td> <td><input style="width: 40px;" type="text"/></td> </tr> </tbody> </table>			Yes	No	Unknown	Last 12 Months	Respirologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Internist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No	Unknown	Recent < 1yr	Total # ever	ED visits since last visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>	Hospitalized since last visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>	ICU admissions since last visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	Systemic steroid use since last visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	Barriers <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes select from the list below) <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Adherence</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Cultural issue</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Financial issue</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lack of private drug plan</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Language</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Literacy</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Medication side effects</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Other <input style="width: 100px;" type="text"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> Effect of substances addiction <input type="checkbox"/> Yes <input type="checkbox"/> No Social/Family issue <input type="checkbox"/> Yes <input type="checkbox"/> No			Yes	No	Adherence	<input type="checkbox"/>	<input type="checkbox"/>	Cultural issue	<input type="checkbox"/>	<input type="checkbox"/>	Financial issue	<input type="checkbox"/>	<input type="checkbox"/>	Lack of private drug plan	<input type="checkbox"/>	<input type="checkbox"/>	Language	<input type="checkbox"/>	<input type="checkbox"/>	Literacy	<input type="checkbox"/>	<input type="checkbox"/>	Medication side effects	<input type="checkbox"/>	<input type="checkbox"/>	Other <input style="width: 100px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Modified Medical Research Council Classification <input type="checkbox"/> N/A <input type="checkbox"/> mMRC 0: I only get breathless with strenuous exertion <input type="checkbox"/> mMRC 1: I get SOB when hurrying on the level or walking up a slight hill <input type="checkbox"/> mMRC 2: I walk slower than other people of the same age on the level, or stop for breath when walking at my own pace <input type="checkbox"/> mMRC 3: I stop for breath after walking 100 meters or after a few minutes <input type="checkbox"/> mMRC 4: I am too breathless to leave the house or I am breathless when dressing or undressing		Triggers and Exposures <input type="checkbox"/> N/A Have there been any changes to your triggers or exposures since last visit <input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Category <small>If yes select patient reported triggers & exposures from list.</small></th> <th colspan="3">Triggers</th> <th colspan="3">Exposures</th> </tr> <tr> <th><input type="checkbox"/> Yes</th> <th><input type="checkbox"/> No</th> <th><input type="checkbox"/> Unknown</th> <th><input type="checkbox"/> Yes</th> <th><input type="checkbox"/> No</th> <th><input type="checkbox"/> Unknown</th> </tr> </thead> <tbody> <tr><td>Beta Blockers</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cats</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Chemicals</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Exercise</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Fireplace/Woodstove</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Food allergy</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Fumes</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Outdoor pollution</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Perfume/Air fresheners</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pollen</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Ragweed</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Respiratory Infections</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Second hand smoke</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other <input style="width: 80px;" type="text"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		Category <small>If yes select patient reported triggers & exposures from list.</small>	Triggers			Exposures			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Beta Blockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cockroaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold air/ Windy day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dust/Dust mites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotion/ Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fireplace/Woodstove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fungi/Mould	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outdoor pollution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perfume/Air fresheners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ragweed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Second hand smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other <input style="width: 80px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Outdoor pollution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
Perfume/Air fresheners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
Pollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
Ragweed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
Respiratory Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
Second hand smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
Other <input style="width: 80px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
CAT Score (https://www.catestonline.org) <input type="checkbox"/> N/A <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>CAT Score</th> <th>Impact level</th> </tr> </thead> <tbody> <tr><td>5</td><td>Upper limit of normal in healthy non-smokers</td></tr> <tr><td>< 10</td><td>Low</td></tr> <tr><td>10 - 20</td><td>Medium</td></tr> <tr><td>> 20</td><td>High</td></tr> <tr><td>> 30</td><td>Very High</td></tr> </tbody> </table> CAT Score <input style="width: 100px;" type="text"/>		CAT Score	Impact level	5	Upper limit of normal in healthy non-smokers	< 10	Low	10 - 20	Medium	> 20	High	> 30	Very High																																																																																																																																																																				
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CTS severity score (symptom burden and the risk of future exacerbations) <input type="checkbox"/> N/A <input type="checkbox"/> Mild: CAT < 10, mMRC 1, No AECOPD* <input type="checkbox"/> Moderate: CAT ≥ 10, mMRC ≥ 2, Low Risk of AECOPD* <input type="checkbox"/> Severe: CAT ≥ 10, mMRC ≥ 2, High Risk of AECOPD* <small>*Patients are considered at Low Risk of AECOPD with ≤ 1 moderate AECOPD in the last year (moderate AECOPD is an event with prescribed antibiotic and/or oral corticosteroids), and did not require hospital admission/ ED visit; or at High Risk of AECOPD with ≥ 2 moderate AECOPD or ≥ 1 severe exacerbation in the last year (severe AECOPD is an event requiring hospitalization or ED visit).</small>																																																																																																																																																																																	
Occupational History Has your occupation changed since last visit? <input type="checkbox"/> Yes <input type="checkbox"/> NO If yes, fill out/click on options below. <input type="checkbox"/> N/A Current Employment Status: Check all the apply. <i>Note - This includes self-employment and working from home:</i> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Shift work <input type="checkbox"/> Modified duties <input type="checkbox"/> Off work due to respiratory health <input type="checkbox"/> Retired <input type="checkbox"/> Other <input style="width: 150px;" type="text"/> Current Employment <input style="width: 150px;" type="text"/> Significant work exposure <input style="width: 200px;" type="text"/>																																																																																																																																																																																	
Environmental Controls <input type="checkbox"/> N/A Environmental Control Measures in Place <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Select patient-reported, control measures in place. Optional: repeat questions for individuals with a secondary home.) <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Suggested</th> <th></th> <th>Yes</th> <th>No</th> <th>Suggested</th> </tr> </thead> <tbody> <tr><td>Air conditioning in summer</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Humidifier in winter (desired target < 50%)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Central or hepa-filter vacuum</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Humidifier all year round (desired target < 50%)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Dehumidifier (desired target < 50%)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input 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Client Name

Jurisdictional Health Number

ComorbiditiesHave your co-morbidities changed since last visit? ☐ Yes ☐ No If yes, fill out/click on options below:☐ N/AComorbid Conditions ☐ Yes ☐ No (If yes, select relevant comorbid diagnosis from the list provided)

Respiratory	Yes	No	Unknown	Cardiovascular	Yes	No	Unknown	Upper Airways	Yes	No	Unknown
A-1 Antitrypsin deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASA Reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral Thrush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Valve Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rhinitis/ Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Respiratory Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other			
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cor Pulmonale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Effusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Artery Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health				Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia/ Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia/Alzheimer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other			
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Implantable Cardioverter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Metabolic				Mitral Valve Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Metabolic Syndromes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Pedal Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Syncope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Transient Ischemic Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

COPD Action Plan☐ N/A**Pulmonary Function Test**☐ N/A

	Yes	No		Spirometry	LLN	PRE		POST	
					Actual	% Pred	Actual	% Pred	
Written COPD action plan provided	<input type="checkbox"/>	<input type="checkbox"/>	YYYY/MM/DD	FVC	Litres (L)	Litres (L)	%	Litres (L)	%
Written COPD action plan revised	<input type="checkbox"/>	<input type="checkbox"/>	YYYY/MM/DD	FEV1	Litres (L)	Litres (L)	%	Litres (L)	%
COPD action plan reviewed & not changed	<input type="checkbox"/>	<input type="checkbox"/>	YYYY/MM/DD	FEV ₁ / FVC	Litres (L)	Litres (L)	%	Litres (L)	%
Yellow or red zone of action plan followed,	<input type="checkbox"/>	<input type="checkbox"/>	# of Times	PEF	Litres (L)/Sec			Litres (L)/Sec	
				DLCO <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Results <input type="text"/>					

Additional Notes

Client Name <input style="width: 250px;" type="text"/>		Jurisdictional Health Number <input style="width: 200px;" type="text"/>																																																																																													
Immunizations <input type="checkbox"/> N/A		Referrals <input type="checkbox"/> N/A																																																																																													
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Immunizations discussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Influenza vaccination received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Date of last influenza vaccination	<input style="width: 100px;" type="text" value="YYYY/MM/DD"/>																																																																																														
Conjugated vaccine (PNEU-C-13)	<input style="width: 100px;" type="text" value="YYYY/MM/DD"/>																																																																																														
Polyvalent Pneumococcal vaccine	<input style="width: 100px;" type="text" value="YYYY/MM/DD"/>																																																																																														
	Yes	No	Suggested																																																																																												
Allergist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
COPD Education Program/ CRE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Respirologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Smoking cessation counselling/support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Dietitian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Mental health counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Sleep study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Allergy testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Home O2 assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
ABGs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Pharmacist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Full PFT testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Pulmonary Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
OTN tele-monitoring program (if available)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Other specialist <input style="width: 150px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																												
Investigations <input type="checkbox"/> N/A		Follow-up Visit Scheduled in (time frame from current visit) <input type="checkbox"/> N/A																																																																																													
Chest CT <input type="checkbox"/> Yes <input type="checkbox"/> No Results <input style="width: 100px;" type="text"/> Bone Mineral Density Test (BMD Test) Date of last <input style="width: 100px;" type="text" value="YYYY/MM/DD"/> Results <input style="width: 100px;" type="text" value="g/cm²"/> Other (past disgnostics) Alpha-1 Antitrypsin blood work done <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Results _____ ABG on room air done and date (consider when FEV ₁ < 40% or resting SpO ₂ < 90%) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date of last <input style="width: 100px;" type="text" value="YYYY/MM/DD"/> Results: pH ____ PO ₂ ____ PCO ₂ ____ HC03 ____ SaO ₂ ____ 6 minute walk test <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Results <input style="width: 100px;" type="text"/>		<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> 1 Week</td> <td><input type="checkbox"/> 1 Month</td> <td><input type="checkbox"/> 4-6 Months</td> <td rowspan="3">Other <input style="width: 100px;" type="text"/></td> </tr> <tr> <td><input type="checkbox"/> 2 Weeks</td> <td><input type="checkbox"/> 2 Months</td> <td><input type="checkbox"/> 6-12 Months</td> </tr> <tr> <td><input type="checkbox"/> 3 Weeks</td> <td><input type="checkbox"/> 3 Months</td> <td><input type="checkbox"/> "Wait and see"</td> </tr> </table>		<input type="checkbox"/> 1 Week	<input type="checkbox"/> 1 Month	<input type="checkbox"/> 4-6 Months	Other <input style="width: 100px;" type="text"/>	<input type="checkbox"/> 2 Weeks	<input type="checkbox"/> 2 Months	<input type="checkbox"/> 6-12 Months	<input type="checkbox"/> 3 Weeks	<input type="checkbox"/> 3 Months	<input type="checkbox"/> "Wait and see"																																																																																		
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Education Interventions <input type="checkbox"/> N/A																																																																																															
Education provided at this visit <input type="checkbox"/> Yes <input type="checkbox"/> No (Identify education provided by selecting from the list below) <table border="0" style="width: 100%; margin-top: 10px;"> <tr> <th style="width: 40%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 40%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> </tr> <tr> <td>Adherence to medications</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Immunotherapy</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Barriers addressed</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Inhaler technique</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>COPD Action Plan</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Medications</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>COPD pathophysiology</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Provide patient education materials</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Coping strategies addressed</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Self management goal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Device technique optimal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Smoking cessation</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Early recognition & treatment of exacerbations</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Triggers & environmental controls</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Environmental tobacco smoke exposure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other <input style="width: 150px;" type="text"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Exercise</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="3"> Patient understanding of education/Information provided at this visit <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent </td> </tr> </table>					Yes	No		Yes	No	Adherence to medications	<input type="checkbox"/>	<input type="checkbox"/>	Immunotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Barriers addressed	<input type="checkbox"/>	<input type="checkbox"/>	Inhaler technique	<input type="checkbox"/>	<input type="checkbox"/>	COPD Action Plan	<input type="checkbox"/>	<input type="checkbox"/>	Medications	<input type="checkbox"/>	<input type="checkbox"/>	COPD pathophysiology	<input type="checkbox"/>	<input type="checkbox"/>	Provide patient education materials	<input type="checkbox"/>	<input type="checkbox"/>	Coping strategies addressed	<input type="checkbox"/>	<input type="checkbox"/>	Self management goal	<input type="checkbox"/>	<input type="checkbox"/>	Device technique optimal	<input type="checkbox"/>	<input type="checkbox"/>	Smoking cessation	<input type="checkbox"/>	<input type="checkbox"/>	Early recognition & treatment of exacerbations	<input type="checkbox"/>	<input type="checkbox"/>	Triggers & environmental controls	<input type="checkbox"/>	<input type="checkbox"/>	Environmental tobacco smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	Other <input style="width: 150px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Patient understanding of education/Information provided at this visit <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent																																		
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Additional Notes/ Plan																																																																																															
Healthcare Professional Role Type <input style="width: 250px;" type="text"/>		Signature <input style="width: 250px;" type="text"/>																																																																																													

