





Client Name <input style="width: 150px;" type="text"/>		Jurisdictional Health Number <input style="width: 150px;" type="text"/>																																																	
<b>Family History of Lung Disease</b> <input type="checkbox"/> N/A		<b>Current Symptoms</b> <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		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Breathlessness <input type="checkbox"/> at rest <input type="checkbox"/> on exertion</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> </tr> <tr> <td>Chest tightness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Wheeze</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cough</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sputum production</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Sputum colour _____</td> </tr> <tr> <td colspan="3">Sputum consistency _____ Sputum volume _____</td> </tr> <tr> <td>Hemoptysis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Frequent colds</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">If yes frequency <input type="checkbox"/> 0-3/year <input type="checkbox"/> 4-7/year <input type="checkbox"/> ≥8/year</td> </tr> <tr> <td>Colds that last longer than 7 days</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Symptoms worse at night (including cough)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Chest pain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Limitation of activities at home</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sleep soundly</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Decreased energy level</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Breathlessness <input type="checkbox"/> at rest <input type="checkbox"/> on exertion	Yes	No	Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	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"/>
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<b>Physical Exam</b> <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 (skinny)																																																			
Vitals: HR _____ RR _____ BP _____																																																			
<b>Smoking</b> <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 ____ )		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																																																	
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	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"/>	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																																																	
Passive Smoking Risk <input type="checkbox"/> Yes <input type="checkbox"/> No	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	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)																																																	
<b>COPD Healthcare Utilization</b> <input type="checkbox"/> N/A		<b>Barriers</b> <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"/>		Barriers <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes select from the list below)																																																	
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<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		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Category <small>If yes select patient reported triggers &amp; 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 type="checkbox"/></td></tr> <tr><td>Cockroaches</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>Cold air/ Windy day</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>Dogs</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>Dust/Dust mites</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>Emotion/ Stress</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>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 type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Fungi/Mould</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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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: 100px;" 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 &amp; 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: 100px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category <small>If yes select patient reported triggers &amp; 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: 100px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																											
<b>CAT Score (<a href="https://www.catestonline.org">https://www.catestonline.org</a>)</b> <input type="checkbox"/> N/A																																																																																																																																																																																	
CAT Score	Impact level																																																																																																																																																																																
5	Upper limit of normal in healthy non-smokers																																																																																																																																																																																
< 10	Low																																																																																																																																																																																
10 - 20	Medium																																																																																																																																																																																
> 20	High																																																																																																																																																																																
> 30	Very High																																																																																																																																																																																
CAT Score _____																																																																																																																																																																																	
<b>CTS severity score (symptom burden and the risk of future exacerbations)</b> <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 <b>Low Risk of AECOPD</b> 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 <b>High Risk of AECOPD</b> with ≥ 2 moderate AECOPD or ≥ 1 severe exacerbation in the last year (severe AECOPD is an event requiring hospitalization or ED visit).</small>																																																																																																																																																																																	
<b>Occupational History</b> <input type="checkbox"/> N/A																																																																																																																																																																																	
Current Employment Status: Check all the apply. Note - This includes self-employment and working from home:																																																																																																																																																																																	
<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 _____ Current Employment _____																																																																																																																																																																																	
Significant work exposure _____																																																																																																																																																																																	
<b>Environmental Controls</b> <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.)																																																																																																																																																																																	
	Yes	No	Suggested																																																																																																																																																																														
Air conditioning in summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Central or hepa-filter vacuum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Dehumidifier (desired target < 50%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Dust mite mattress cover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Dust mite pillow cover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Removed carpets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Heat exchanger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Heating gas/Oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Heating electric/Radiator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Alternative to wood heat (fireplaces, wood stoves, furnaces) or mitigation strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Humidifier in winter (desired target < 50%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Humidifier all year round (desired target < 50%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Non-feather blanket	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Pets kept out of bedrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Regular furnace filter change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Remove pets from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Wash linens in hot water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Wash pets once a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Wear mask or respirator as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														
Other <input style="width: 100px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																														

Client Name

Jurisdictional Health Number

## Comorbidities

N/A

Comorbid 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	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 <sub>1</sub> / 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			

## Additional Notes/ Plans

Client Name <input style="width:250px;" type="text"/>			Jurisdictional Health Number <input style="width:200px;" type="text"/>				
<b>Immunizations</b> <input type="checkbox"/> N/A			<b>Referrals</b> <input type="checkbox"/> N/A				
	Yes	No	Unknown		Yes	No	Suggested
Immunizations discussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza vaccination received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COPD Education Program/ CRE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last influenza vaccination	<input style="width:100px;" type="text" value="YYYY/MM/DD"/>			Respirologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conjugated vaccine (PNEU-C-13)	<input style="width:100px;" type="text" value="YYYY/MM/DD"/>			Smoking cessation counselling/support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polyvalent Pneumococcal vaccine	<input style="width:100px;" type="text" value="YYYY/MM/DD"/>			Dietitian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<a href="https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci.html">https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci.html</a>				Mental health counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Investigations</b> <input type="checkbox"/> N/A				Sleep testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest CT	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Results <input style="width:100px;" type="text"/>	Allergy testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone Mineral Density Test (BMD Test)				Home O2 assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last	<input style="width:100px;" type="text" value="YYYY/MM/DD"/>	Results	<input style="width:100px;" type="text" value="g/cm²"/>	ABGs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (past diagnostics)				Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alpha-1 Antitrypsin blood work done	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Pharmacist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Results	<input style="width:200px;" type="text"/>			Full PFT testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABG on room air done and date (consider when FEV <sub>1</sub> < 40% or resting SpO <sub>2</sub> < 90%)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Pulmonary Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last	<input style="width:100px;" type="text" value="YYYY/MM/DD"/>			OTN tele-monitoring program (if available)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Results: pH ____ PO <sub>2</sub> ____ PCO <sub>2</sub> ____ HC03 ____ SaO <sub>2</sub> ____				Other specialist	<input style="width:150px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 minute walk test	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<b>Follow-up Visit Scheduled in (time frame from current visit)</b> <input type="checkbox"/> N/A			
Results	<input style="width:100px;" type="text"/>			<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"	
<b>Education Interventions</b> <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)	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	
<b>Additional Notes/ Plans</b>							
Healthcare Professional Role Type <input style="width:200px;" type="text"/>				Signature <input style="width:200px;" type="text"/>			

