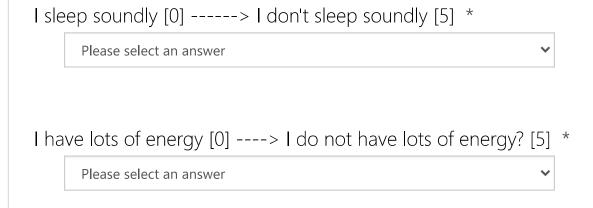
YOUR DETAILS

ate of Birth *			
dd/mm/yyyy 🗖			
ana Numbar *			
one Number *			
none Number *			

COPD ASSESSMENT TEST

Please rate your answers with 0 being the lowest, 5 being the highest

I never cough [0]> I cough all the	time [5] *
Please select an answer	•
I have no phlegm (mucus) in my chest at a	ll [0]> to my chest is completely full of phlegm (mucus) [5] *
Please select an answer	~
My chest does not feel tight at all [0]	-> my chest feels very tight[5] *
Please select an answer	~
When I walk up a hill/flights of stairs I am r	ot breathless [0]> when I walk up a hill or one flight or stairs I am very
breathless? [5] *	
Please select an answer	→
I am not limited doing activities at home [6]> I am limited doing activities at home? [5] *
Please select an answer	~
I am confident leaving my home despite n	y lung condition[0]> I am not condition leaving my home because of my lur
condition? [5] *	
Please select an answer	· ·



THIS FORM COLLECTS YOUR NAME, DATE OF BIRTH, EMAIL, OTHER PERSONAL INFORMATION AND MEDICAL DETAILS. THIS IS TO CONFIRM YOU ARE REGISTERED WITH THE PRACTICE, TO ALLOW THE PRACTICE TEAM TO CONTACT YOU AND ALSO TO UPDATE YOUR MEDICAL RECORDS HELD BY THE PRACTICE AND OUR PARTNERS IN THE NHS. PLEASE READ OUR PRIVACY POLICY TO DISCOVER HOW WE PROTECT AND MANAGE YOUR SUBMITTED DATA *

O I consent to the practice collecting and storing my data from this form.