

YOUR DETAILS

Name *

Date of Birth *

 

Phone Number *

Email Address

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 all [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 not 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 [0] -----> I am limited doing activities at home? [5] *

Please select an answer



I am confident leaving my home despite my lung condition[0] -----> I am not confident leaving my home because of my lung condition? [5] *

Please select an answer



I sleep soundly [0] -----> I don't sleep soundly [5] *

Please select an answer



I have lots of energy [0] -----> I do not have lots of energy? [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 *

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