UCLA Health

Pulmonary Rehabilitation Program

PATIENT HEALTH ASSESSMENT

Name: _____ Preferred Contact Number: _____

TOBACCO HISTORY:

☐ None ☐ Current smoker ☐ Past Smoker Date Quit: _____

How many packs per day? _____ How many years? _____

PLEASE CHECK THE BOX THAT APPLIES TO YOU:

Grade		
0	☐	I get breathless with strenuous exercise
1	☐	I get short of breath when hurrying on level ground or walking up a slight hill
2	☐	I walk slower than people of the same age because of breathlessness or I have to stop for breath when walking at my own pace
3	☐	I have to stop for a breath after walking about 100 yards or after a few minutes on level ground
4	☐	I am too breathless to leave the house, or I am breathless when dressing or dressing

BREIFY TELL US WHY YOU WERE REFERRED TO PULMONARY REHAB: _____

_____

WHAT DO YOU HOPE TO ACHIEVE FROM THIS PROGRAM? _____

_____

DO YOU HAVE ANY EXERCISE EQUIPMENT AT HOME? IF YES, WHAT TYPE? (EXAMPLE: TREADMILL, STATIONARY BICYCLE, ETC.)

_____

DO YOU PERFORM ANY OTHER TYPES OF PHYSICAL ACTIVITY SUCH AS STRETCHING, YOGA, STRENGTH TRAINING? IF YES, HOW MANY DAYS PER WEEK AND FOR HOW LONG DO YOU DO THESE ACTIVITIES?

_____

UCLA Health

COPD ASSESSMENT TEST (CAT)

MRN:
Patient Name:

(Patient Label)

How is your COPD? Take the COPD Assessment Test ™ (CAT)

This questionnaire will help you and your healthcare professional measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on our wellbeing and daily life. Your answers, and test score can be used by you and your healthcare professional to help improve the management of your COPD and get the greatest benefit from treatment.

For each item below, place a mark (X) in the box that best describes you currently. Be sure to only select one response for each question.

Example: I am very happy ⓪ ① ② ③ ④ ⑤ I am very sad

								SCORE
I never cough	⓪	①	②	③	④	⑤	I cough all the time	
I have no phlegm (mucus) in my chest at all	⓪	①	②	③	④	⑤	My chest is completely full of phlegm (mucus)	
My chest does not feel tight at all	⓪	①	②	③	④	⑤	My chest feels very tight	
When I walk up a hill or one flight of stairs I am not breathless	⓪	①	②	③	④	⑤	When I walk up a hill or one flight of stairs I am very breathless	
I am not limited doing any activities at home	⓪	①	②	③	④	⑤	I am very limited doing activities at home	
I am confident leaving my home despite my lung condition	⓪	①	②	③	④	⑤	I am not at all confident leaving my home because of my lung condition	
I sleep soundly	⓪	①	②	③	④	⑤	I don't sleep soundly because of my lung condition	
I have lots of energy	⓪	①	②	③	④	⑤	I have no energy at all	
							Total Score	

UCLA Health

COPD ASSESSMENT TEST (CAT)

MRN:
Patient Name:

(Patient Label)

Patient or Representative Signature _____

Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____

Date _____ Time _____

UCLA Health

GAD – 7

MRN:
Patient Name:

(Patient Label)

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all

☐ Somewhat difficult

☐ Very difficult

☐ Extremely difficult

Patient or Representative Signature _____

Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____

ID # _____ Date _____ Time _____

(For office coding: Total Score – T_____ = _____ + _____ + _____)

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

UCLA Health

MRN:
Patient Name:

(Patient Label)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems? Please CHECK one.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3
For Staff Use Only **Total _____ =**	____	+ _____	+_____	+_____

Patient or Representative Signature | Date | Time

If not signed by patient, indicate relationship or guardian: _____

Interpreter Signature | Interpreter ID # | Date | Time