Mary Washington Healthcare

Pulmonary Rehabilitation Self-Assessment Form

Date: _________

Shortness of Breath:
Please check the statement that best fits your daily level of shortness of breath.

_____ 0 No trouble with shortness of breath except with strenuous exercise such as running or carrying 25 lbs. while walking up hill.

_____ 1 You feel short of breath while walking on a flat level of ground in a hurry or walking up a slight hill.

_____ 2 You walk slower than others of the same age or have to stop to catch your breath while walking on level ground because of shortness of breath.

_____ 3 You have to stop to catch your breath after walking a short distance (less than 100 yards, less than the length of a football field) or after walking for just a few minutes on level ground.

_____ 4 You are too breathless to leave the house or are too breathless to dress and fix meals.

Sleeping Pattern:
How many total hours of sleep do you get on average? ____________________________
Do you have to sleep with your head elevated on more than 1 pillow? _______________

Nutrition Information:
How would you rate your appetite? ____ Good ____ Fair ____ Poor
Do you get short of breath when you eat? Yes No Sometimes
How many meals do you eat daily? ____________________________ Snacks: __________
How many 8 oz. glasses of water do you drink per day? _____________
Do you follow a special diet?___Yes ___No If yes, what type?______________________

Family Support:
Are there any issues/aspects with your family or home situation that would interfere with your rehab sessions or treatment? No__ Yes___ If yes, explain: __________________________
____

Do you have family members living in your house that actively participate in your daily living?
No____ Yes____

Are your family members mentally and emotionally supportive regarding your lung disease and planned/ongoing rehabilitation? No___ Yes____ If no, explain: __________________________

Patient Label

Check any of the following activities that you have difficulty doing without assistance.
(Include activities that you always have someone else do because of your inability to do them).

Eating: Cutting up you food ___ Sitting for a whole meal_____ Drinking from a cup____

Meal Preparation:
Peeling/cutting up food_____ Stir or steam foods____
Bending to obtain items____ Reaching to obtain items____
` Hand washing dishes______ Loading/unloading dishwasher____
Setting the table______ Clearing the table______
Taking out the garbage_____

Hygiene:
Taking a shower or bath______ Washing your back________
Washing your legs and feet_____ Drying yourself with a towel_____
Shaving_____ Putting on make up_____

Household:
Cleaning: Making the bed______
Running the vacuum or mopping____
Dusting high and low places_____
Moving chairs or tables to vacuum or dust_____

Laundry:
Sorting clothes_____
Getting clothes up or down stairs______
Using washing machine or dryer______
Folding laundry_____
Ironing clothes______

Functional Mobility: Getting in or out of the tub ______
Getting up or down stairs_______
Opening or closing car doors______
Walking in a store_____
Walking about the house______
Taking out the trash______
Carrying groceries in or out of car____

Miscellaneous:
Difficulty relaxing______
Panic when short of breath_____
Fatique at end of day______
Holding objects______
Reaching or lifting things overhead___
Bending to pick things up or tying shoes______

Check the usual household activities that you do:
___cooking ____cleaning ___Finances
___Laundry ____Driving ___Yard work ____ grocery shopping

Transportation: _____ Currently drive ____ Rely on family ____ Rely on Friends
_____ Use public transportation _____ Is a real problem for me

Patient Label

Occupation History:

Current or former occupation: ____

Retirement/Disability Date: ____

Were you ever exposed to the following:

____ Welding ____Pottery ____ Asbestos ____ Mines/foundry

____ Gas/fumes ____Quarry ____ Sandblasting ____ Chemicals

____ Dust

Allergy History:

Do you see an allergist? Yes No

I am allergic to the following:

Foods: ____

Medications: ____

Environmental: _____ Dust ____ Mold ____Pollens _____Grass

_____ Other______________

Do you have difficulty breathing when exposed to any of the following:

____Dust ____ Smog ____ Solvents ____ Humidity

____ Wind ____ Perfumes or colones ____ Tobacco smoke

____ Changes in temperature or weather

Vaccine History:

Do you receive the flu vaccine annually? ____ Yes ____ No

Have you ever received the pneumonia vaccine? ____ Yes ____ No

Exercise Activity:

Do you do exercise on a regular basis? ____ Yes ____ No

If yes, what do you do? ____

What type of exercise equipment do you have at home or have access to?

____

Assistive Devices:

Do you use any of the following on occasion or on a regular basis?

____ Walker ____ Cane ____ Wheelchair

____ Electric cart ____ 4 leg cane ____ Eye glasses

____ Hearing aids

Respiratory Care Equipment:

Do you have or use any of the following at home?

____ Peak flowmeter ____ Flutter Valve ___Incentive Spirometer

____ Mechanical chest percussor ____ Nebulizer machine ___ Suction machine

____ BiPAP or ventilator machine ____ CPAP machine

___ Oxygen: What type? ___ Concentrator ___Tanks ___Liquid ___pulse ___Portable

When do you use it? ____

Advanced Directive:

Do you have an advanced directive? _____ Yes _____No

Do you have a power of attorney to make medical decisions? ____ Yes _____No

Patient Label