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 your 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____
Fatigue 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
e______ Use public transportation ______ Is a real problem for me
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: _______Dust ___ Mold ___ Pollens ___ Grass
Environmental:   _____ Dust _____ Mold _____ Pollens _____ Grass
____________________
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