

# Chronic Obstructive Pulmonary Disease

Producer \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Client \_\_\_\_\_ Age/DOB \_\_\_\_\_ Sex \_\_\_\_\_

If your client has a chronic pulmonary (lung) disease, please answer the following:

1. Type of lung disease:

chronic bronchitis

emphysema

restrictive lung disease

asthma

2. Please list date when first diagnosed: \_\_\_\_\_

no

3. Has your client ever been hospitalized for this condition?

yes, please give details \_\_\_\_\_

no

4. Has your client ever smoked?

yes, and currently smokes \_\_\_\_\_ (amount/day)

yes, smoked in the past but quit \_\_\_\_\_ (date)

never smoked

5. Is your client on any medications (include inhalers)?

yes

no

6. Have pulmonary function tests (a breathing test) ever been done?

yes, please give most recent test results \_\_\_\_\_

no

7. Please note client's build:

Height \_\_\_\_\_ Weight \_\_\_\_\_

8. Does your client have any abnormalities on an ECG or x-ray?

yes, please give details \_\_\_\_\_

no

9. Does your client have any other major health problems (ex: heart disease, etc.)?

yes, please give details \_\_\_\_\_

no