

COPD SELF CHECK TOOL

Chronic Obstructive Pulmonary Disease (COPD) is the name for a group of long-term and progressive lung diseases. This self-check tool will help you define how COPD affects you individually so you can be your own leader in managing your condition.

<p>My Triggers : (Triggers are actions or substances that cause your COPD to worsen or flare up. *Check all that apply)</p> <p><input type="checkbox"/> Tobacco/secondhand smoke</p> <p><input type="checkbox"/> Vaping</p> <p><input type="checkbox"/> Chemical fumes</p> <p><input type="checkbox"/> Dust</p> <p><input type="checkbox"/> Pet dander</p> <p><input type="checkbox"/> Strong odors/inhaled scents</p> <p><input type="checkbox"/> Pollution</p> <p><input type="checkbox"/> Hot weather</p> <p><input type="checkbox"/> Cold weather</p> <p><input type="checkbox"/> Illness</p> <p>Others: _____</p> <p>_____</p> <p>_____</p>	<p>My Triggers cause: *Check all that apply</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Change in color/consistency/amount of mucus</p> <p><input type="checkbox"/> Chest tightness</p> <p><input type="checkbox"/> Fatigue/limitation of activities</p> <p><input type="checkbox"/> Increased use of meds</p> <p><input type="checkbox"/> Swelling in the feet, leg, or ankles</p> <p><input type="checkbox"/> Blueness of the lips or fingernails</p> <p><input type="checkbox"/> Problems with sleep</p> <p><input type="checkbox"/> Anxiety</p> <p>Others: _____</p> <p>_____</p> <p>_____</p>
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Pay attention to your body and learn/know your own “normal” or baseline. Recognizing early symptoms of a flare-up means you can help decrease its severity and potentially avoid an admission to the hospital.

<p>Things that help keep my COPD controlled : *Check all that apply</p> <p><input type="checkbox"/> Rescue and maintenance inhalers</p> <p><input type="checkbox"/> Breathing exercises</p> <p><input type="checkbox"/> Oxygen</p> <p><input type="checkbox"/> Cpap/bipap</p> <p><input type="checkbox"/> Flu/pneumo vaccines as recommended</p> <p><input type="checkbox"/> Frequent handwashing</p> <p><input type="checkbox"/> Symptom diary</p> <p><input type="checkbox"/> Pulmonary rehab</p> <p><input type="checkbox"/> Cover mouth or nose when outside</p> <p><input type="checkbox"/> Use of incentive spirometer/flow meter to monitor baseline lung function</p> <p><input type="checkbox"/> Pulse oximeter to monitor oxygen levels</p> <p>Others: _____</p> <p>_____</p> <p>_____</p>	<p>When I have a flare, these are the steps I follow: *Check all that apply</p> <p><input type="checkbox"/> Call primary care physician</p> <p><input type="checkbox"/> Call pulmonologist</p> <p><input type="checkbox"/> Call for rescue rx -antibiotic/steroids</p> <p><input type="checkbox"/> Use nebulizer</p> <p><input type="checkbox"/> Use rescue inhaler</p> <p><input type="checkbox"/> Apply oxygen</p> <p>**Take your action plan to you physician for review and discussion of flare up steps to follow.</p> <p>Others: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Primary Care Physician: _____ Phone #: _____

Pulmonologist: _____ Phone #: _____

COPD SELF CHECK TOOL

My COPD MEDS

Quick acting bronchodilators:(Rescue inhaler/nebulizer)

- ___ Albuterol (proair, Ventolin)
- ___ Levalbuterol (Xopenex)
- ___ Ipratropium (Atrovent)
- ___ Albuterol/ipratropium (combivent Respimat)

Long acting bronchodilators: (inhalers/nebulizers)

- ___ Aclidinium (Tudorza)
- ___ Arformoterol (Brovana)
- ___ Formoterol (Foradil, Perforomist)
- ___ Glycopyrrolate (Seebri Neohaler, Lonhala Magnair)
- ___ Indacaterol (Arcapta)
- ___ Olodaterol (Striverdi Respimat)
- ___ Revfenacin (Yupelri)
- ___ Salmeterol (serevent)
- ___ Tiotropium (Spiriva)
- ___ Umeclidinium (Incruse Ellipta)

Corticosteroids:

- ___ Fluticasone (Flovent inhaler)
- ___ Budesonide (Pulmicort – inhaler/nebulizer)
- ___ Prednisolone (pill, liquid, shot)

Methylxanthines: anti-inflammatory drug that relaxes muscles in the airways

- ___ Theophylline (pill or liquid)

Combo - 2 long acting bronchodilators:

- ___ Aclidinium/formoterol (Duaklir)
- ___ Glycopyrrolate/formoterol (Bevespi Aerosphere)
- ___ Tiotropium/olodaterol (Stiolto Respimat)
- ___ Umeclidinium/vilanterol (Anoro Ellipta)

Combo - corticosteroid and a long acting bronchodilator:

- ___ Budesonide/formoterol (Symbicort)
- ___ Fluticasone/salmeterol (Advair)
- ___ Fluticasone/vilanterol (Breo Ellipta)

Triple Therapy: an inhaled corticosteroid and 2 long acting bronchodilators:

- ___ Fluticasone/vilanterol/umeclidinium (Trelegy Ellipta)

Antibiotics: Your doctor may prescribe one when you have an infection. Complete the entire course so the infection doesn't come back or become resistant to the antibiotic.

Rinse your mouth with water immediately after using a steroid inhaler to prevent thrush, a yeast infection of the throat.



COPD SELF CHECK TOOL

Self-Management Goal



Exercise * Healthy Eating * Take all medication as directed and use properly * Reduce Stress

*** Avoid Triggers * Quit SMOKING * Better Breathing Techniques * Get a Flu Shot**

My goal is to work on: <i>Example: Exercise</i>	
I will do this by (what): <i>Example: walking</i>	
I will do this for (how much): <i>Example: 20 minutes</i>	
I will do this (when): <i>Example: in the evening</i>	
I will do this on (how often): <i>Example: M, W, F (3 days a week)</i>	
Barriers to my goal:	

Listed below are things you can do to help yourself maintain you best health while managing your COPD and are good ideas to pick goals from!

- | | |
|---|---|
| <ul style="list-style-type: none"> • Take medications as directed and use properly • Follow up with your physician as scheduled and after “flare-ups” • Avoid exposure to people sick with respiratory illnesses • Avoid triggers • Maintain a healthy weight • Learn to cough effectively • Learn proper techniques to use inhalers • Eat a well-balanced diet, eat small meals often (they are easier to digest) • Quit smoking – 1-800-QUIT-NOW | <ul style="list-style-type: none"> • Exercise each day • Get at least 7 hours of sleep each night • Get emotional support as needed. • Maintain good control of your other conditions • Reduce Stress • Stay current with flu/Pneumo vaccines • Attend Pulmonary Rehab - This helps you find support in managing your COPD, teaches you how to exercise and lets you practice under medical supervision, and teaches breathing/coughing techniques. This requires an order from your physician or pulmonologist. |
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COPD SELF CHECK TOOL



My COPD Action Plan

It is recommended that patients and physicians/healthcare providers complete this action plan together. This plan should be discussed at each physician visit and updated as needed.

The green, yellow and red zones show symptoms of COPD. The list of symptoms is not comprehensive, and you may experience other symptoms. In the "Actions" column, your healthcare provider will recommend actions for you to take based on your symptoms by checking the appropriate boxes. Your healthcare provider may write down other actions in addition to those listed here.

Green Zone: I am doing well today

- Usual activity and exercise level
- Usual amounts of cough and phlegm/mucus
- Sleep well at night
- Appetite is good

Actions

- Take daily medicines
- Use oxygen as prescribed
- Continue regular exercise/diet plan
- At all times avoid cigarette smoke, inhaled irritants*
- _____

Yellow Zone: I am having a bad day or a COPD flare

- More breathless than usual
- I have less energy for my daily activities
- Increased or thicker phlegm/mucus
- Using quick relief inhaler/nebulizer more often
- Swelling of ankles more than usual
- More coughing than usual
- I feel like I have a "chest cold"
- Poor sleep and my symptoms woke me up
- My appetite is not good
- My medicine is not helping

Actions

- Continue daily medication
- Use quick relief inhaler every _____ hours
- Start an oral corticosteroid (specify name, dose, and duration)

- Start an antibiotic (specify name, dose, and duration)

- Use oxygen as prescribed
- Get plenty of rest
- Use pursed lip breathing
- At all times avoid cigarette smoke, inhaled irritants*
- Call provider immediately if symptoms don't improve*
- _____

Red Zone: I need urgent medical care

- Severe shortness of breath even at rest
- Not able to do any activity because of breathing
- Not able to sleep because of breathing
- Fever or shaking chills
- Feeling confused or very drowsy
- Chest pains
- Coughing up blood

Actions

- Call 911 or seek medical care immediately*
- While getting help, immediately do the following:
- _____

*The American Lung Association recommends that the providers select this action for all patients.

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COPD SELF CHECK TOOL



MY COPD MANAGEMENT PLAN

It is recommended that patients and physicians/healthcare providers complete this management plan together. This plan should be discussed at each physician visit and updated as needed.

General Information

Name: _____ Date: _____
 Emergency Contact: _____ Phone Number: _____
 Physician/Health Care Provider Name: _____ Phone Number: _____

Lung Function Measurements

Weight: _____ lbs FEV1: _____ L _____ % predicted Oxygen Saturation: _____ %
 Date: _____ Date: _____ Date: _____

General Lung Care

Flu vaccine _____ Pneumococcal conjugate vaccine (PCV13) <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumococcal polysaccharide vaccine (PPSV23) <input type="checkbox"/> Yes <input type="checkbox"/> No	Date received: _____ Date received: _____ Date received: _____	Next Flu vaccine due: _____ Next PCV13 vaccine due: _____ Next PPSV23 vaccine due: _____
Smoking status _____	<input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	Quit Smoking Plan <input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise plan <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Walking <input type="checkbox"/> Other _____ min/day _____ days/week	Pulmonary Rehabilitation <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Goal Weight: _____	

Medications for COPD

Type or Descriptions of Medicines	Name of Medicine	How Much to Take	When to Take

My Quit Smoking Plan

<input type="checkbox"/> Advise: Firmly recommend quitting smoking	<input type="checkbox"/> Discuss use of medications, if appropriate: _____
<input type="checkbox"/> Assess: Readiness to quit	<input type="checkbox"/> Freedom From Smoking* <input type="checkbox"/> Lung HelpLine Lung.org/ffs 1-800-LUNG USA
<input type="checkbox"/> Encourage: To pick a quit date	
<input type="checkbox"/> Assist: With a specific cessation plan that can include materials, resources, referrals and aids	

Oxygen

Resting: _____ Increased Activity: _____ Sleeping: _____

Advanced Care and Planning Options

Advance Directives (incl. Healthcare Power of Attorney): _____

Other Health Conditions

Anemia Anxiety/Panic Arthritis Blood Clots Cancer Depression
 Diabetes GERD/Acid Reflux Heart Disease High Blood Pressure Insomnia Kidney/Prostate
 Osteoporosis Other: _____