Your name:	Today's date:

COPD Assessment Test

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 your 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 **X** 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**	

Last Updated: February 24, 2012

TOTAL SCORE

UCSD Shortness of Breath Questionnaire
PRE/POST

INSTRUCTIONS: For each activity listed below, rate your breathlessness on a scale between 0 (not at all SOB) and 5 (maximally SOB or too SOB to do the activity). If the activity is one that you do not perform, give your best estimate of breathlessness. Your responses should be for an "average" day during the past week. Please response to all items.

SCALE:
0=NO SOB AT ALL
1=LITTLE SOB NOTED
2=SOMEWHAT SOB
3=MODERATELY SOB
4=SEVERLY SOB
5=MAXIMALLY SOB OR UNABLE TO DO BECAUSE OF SOB

HOW SHORT OF BREATH DO YOU GET:

1. At rest	0	1	2	3	4	5
2. Walking on a level at your own pace	0	1	2	3	4	5
3. Walking on a level with others your age	0	1	2	3	4	5
4. Walking up a hill	0	1	2	3	4	5
5. Walking up stairs	0	1	2	3	4	5
6. While eating	0	1	2	3	4	5
7. Standing up from a chair	0	1	2	3	4	5
8. Brushing teeth	0	1	2	3	4	5
9. Shaving and/or brushing hair	0	1	2	3	4	5
10. Showering/bathing	0	1	2	3	4	5
11. Dressing	0	1	2	3	4	5
12. Picking up and straightening	0	1	2	3	4	5
13. Doing dishes	0	1	2	3	4	5
14. Sweeping/vacuuming	0	1	2	3	4	5
15. Making the bed	0	1	2	3	4	5
16. Shopping	0	1	2	3	4	5
17. Doing laundry	0	1	2	3	4	5
18. Washing the car	0	1	2	3	4	5
19. Mowing the lawn	0	1	2	3	4	5
20. Watering the lawn	0	1	2	3	4	5
21. Sexual activities	0	1	2	3	4	5

HOW MUCH DO THESE LIMIT YOU IN YOUR DAILY LIFE?

22. Shortness of breath	0	1	2	3	4	5
23. Fear of "hurting myself" by overexerting	0	1	2	3	4	5
24. Fear of shortness of breath	0	1	2	3	4	5

PATIENT NAME:_____**DOB**_____
UCSD QUESTIONNAIRE

SCORE_____