





**Blood (hemoptysis):**

No Yes

If yes, how many times: \_\_\_\_\_

Amount: Trace  
1 tbsp  
 $\frac{1}{4}$  cup  
 $\frac{1}{2}$  cup

Change since last visit: Less  
Same  
More

**Shortness of breath:**

No Yes

If yes, how often: Less than once a week  
More than once a week  
Daily

If yes, when: At rest  
Slight activity  
Moderate activity  
Heavy activity only

Change since last visit: Better  
Same  
Worse

**Wheezing:**

No Yes

If yes: Less than once a week  
More than once a week  
Daily

Triggers: Unknown  
Exercise  
Other: \_\_\_\_\_

Change since last visit: Better  
Same  
Worse

**Chest tightness:**

No Yes

If yes: Less than once a week  
More than once a week  
Daily

Change since last visit: Better  
Same  
Worse

**Chest pain:**

No Yes

If yes: Less  
Same  
More

Description: Sharp  
Dull  
Other: \_\_\_\_\_

Where: \_\_\_\_\_

How severe: Mild  
Moderate  
Severe

How often: Less than once a week  
More than once a week  
Daily or more

**Night Time Symptoms**

No Yes

If yes: Less than once a week  
More than once a week  
Daily

Nature: Cough  
Wheeze  
Chest pain  
Shortness of breath  
Other

Wakes me up: No Yes

Change since last visit: Better  
Same  
Worse



**Bowel movements:** How often: \_\_\_\_\_ per day

Normal

Abnormal: Loose  
Greasy  
Black (tarry)  
Blood

**Other:** Flatulence (gas)

Nausea  
Vomiting  
Heartburn  
Bloating  
Swelling

**OTHER SYMPTOMS**

Fever  
Headaches  
Joint pain  
Menstrual  
Sleep disturbance  
Skin rash  
Urine leaking with coughing  
Other (please specify) :

<p>I would like to learn more about:</p> <p>Transplantation: _____</p> <p>Osteoporosis: _____</p> <p>Fertility/Sexuality: _____</p> <p>CF related diabetes (CFRD): _____</p> <p>Distal Intestinal Obstruction Syndrome (DIOS): _____</p> <p>Dealing with an employer: _____</p> <p>Disability Benefits: _____</p> <p>Living Wills: _____</p> <p>Disability Tax Credit: _____</p> <p>Drug insurance Plans: _____</p>	<p>I have had my yearly flu shot _____</p> <p>Any exposure to cigarette smoke? _____</p> <p>I perform regular cleaning (after each use - soap &amp; water) and sterilizing (daily boiling x 10 min.) of nebulizer (just mouthpiece not the tube)_____</p> <p>I know to replace nebulizer every 6 months_____</p> <p><u>CF related Diabetes Monitoring:</u></p> <p>I have had my yearly OGTT test _____</p> <p>Blood sugar monitoring (if applicable): I check my blood sugar: Before meals _____recent levels_____</p> <p>2 hrs after meals _____ recent levels_____</p> <p>Only when sick _____ recent levels _____</p> <p>Recent blood sugar lows _____</p>
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