

Children's Hospital, LHSC  
Cystic Fibrosis: Paediatric Clinic

**Patient Report and Review**

**NAME:** \_\_\_\_\_ **DATE OF VISIT:** \_\_\_\_\_

Please complete the following information about details of your CF Health care since your last visit.

**MEDICAL CONTACTS SINCE LAST VISIT**

Circle yes or no to the following events that may have occurred since your last clinic visit.

- |   |     |    |
|---|-----|----|
| 1. Hospital/Emergency room visit(s)                   | YES | NO |
| 2. Attended other clinics/doctors appointments        | YES | NO |
| 3. Had additional treatments/tests                    | YES | NO |
| 4. Had consultation/referral to other health agencies | YES | NO |

If you answered yes to any of the above, please give detail below:

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**Any problems with:**

- |   |     |    |
|---|-----|----|
| Doing chest physio (percussion, PEP, etc) | YES | NO |
| Taking your inhalation treatments         | YES | NO |
| Taking enzymes or vitamins                | YES | NO |
| Issues at school related to CF            | YES | NO |

Other concerns or problems you wish to discuss/get more information on:

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## SYMPTOMS

Circle the words that most closely describe your symptoms.

### CHEST

Overall change since last visit:      Much Better  
Better  
Same  
Worse  
Much Worse

Cough:                      No                      Yes

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

What is it like:                      Dry  
Loose

When does it occur:                      Day time only  
Night time only  
Day and night time

If it occurs at night, does it wake you up:      No                      Yes

Change since last visit:                      Less  
Same  
More

Sputum:                      No                      Yes

If yes:  
Amount:                      Small  
Medium  
Large

Colour:                      Clear  
Yellow  
Green  
Brown

Consistency:                      Thick  
Thin

Blood streaking: No  
Occasional  
Frequent

Blood: No Yes  
If yes, how many times: \_\_\_\_\_

Amount: Trace  
1tbsp  
¼ cup  
½ 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  
At night time

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







MASK THERAPY

Ventolin      Dose: \_\_\_\_\_ Morning      Afternoon      Evening      Bedtime

Hypertonic Saline \_\_\_\_\_% Morning      Afternoon      Evening      Bedtime

Pulmozyme                      Morning      Afternoon      Evening      Bedtime

TOBI 300mg                      Morning                              Evening

Tobramycin      Dose: 80/160mg Morning      Afternoon      Evening      Bedtime  
Do you take Tobramycin:                      All the time

**Or**

One month on, one month off

**Or**

Treated for \_\_\_\_\_ (#) Days

Date of last course: \_\_\_\_\_

PUFFERS

Salbutamol (Ventolin)                      Dose: \_\_\_\_\_ When: \_\_\_\_\_

Beclomethasone (Qvar, Beconase)      Dose: \_\_\_\_\_ When: \_\_\_\_\_

Flovent                                      Dose: \_\_\_\_\_ When: \_\_\_\_\_

Budesonide                              Dose: \_\_\_\_\_ When: \_\_\_\_\_

Bricanyl                                      Dose: \_\_\_\_\_ When: \_\_\_\_\_

Other: \_\_\_\_\_

NASAL SPRAYS

Nasonex                                      Dose: \_\_\_\_\_ When: \_\_\_\_\_

Flonase                                      Dose: \_\_\_\_\_ When: \_\_\_\_\_

Normal saline rinse                      Dose: \_\_\_\_\_ When: \_\_\_\_\_

Other: \_\_\_\_\_

ANTIBIOTICS

Azithromycin      Dose: \_\_\_\_\_

Cloxacillin      Dose: \_\_\_\_\_

Ciprofloxacin      Dose: \_\_\_\_\_

Keflex              Dose: \_\_\_\_\_

Septra              Dose: \_\_\_\_\_

Other: \_\_\_\_\_

Date of last course: \_\_\_\_\_

# of days treated \_\_\_\_\_

OTHER MEDICATIONS/ALTERNATIVE TREATMENTS

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PHYSIOTHERAPY

Type: PEP                      Chest Percussion                      Vest  
Frequency: \_\_\_\_\_x per day