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 clincs/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:

_____
_____
_____
_____
_____

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:

_____
_____
_____
_____
_____
_____
_____
_____

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

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

EARS, NOSE , MOUTH AND THROAT

Nose and sinus symptoms: No Yes

If yes:

Nasal Discharge:
- Clear
- Yellow
- Green

- Nose bleeds
- Stuffy nose
- Itchy nose
- Face/jaw pain
- Polyps
- Allergies
- Post nasal drip
- Other:_____

Ear Symptoms: No Yes

If yes: Pain
Hearing problems
Other:_____

Mouth Symptoms: No Yes
If yes:
Soreness: Tongue
Mouth
Throat
Other:_____

STOMACH/DIGESTION

Appetite: Good Better
Fair Same
Poor Worse

Weight: Increased
Same
Decreased

Stomach Pain: No Yes
If yes: Less than once a week
More than once a week
Daily or more

Triggers: Food
Not enough enzymes
Other:_____

Relievers:_____

Where is the pain: Upper Lower
Central Flank(s)

Nature: Crampy
Sharp
Steady

Change since last visit: Better
Same
Worse

Bowel movements: How many?_____ per day

Normal
Abnormal

	Loose	
	Greasy	
	Black (tarry)	
	Blood	
Other:	Flatulence (gas)	Nausea
	Rectal Prolapse	Vomiting
	Heartburn	Bloating
	Swelling	

OTHER GENERAL SYMPTOMS

Sleep disturbances
Headaches
Skin rash
Burning on urination
Joint pain
Menstrual
Other (please specify)

_____
_____
_____
_____
_____
_____

MEDICATIONS

ENZYMES

Cotazyme Powder — Quantity: _____per meal
Cotazyme ECS 8/20 — _____per snack
Creon 10/25
Ultrase 12/25
Viokase
Other_____

VITAMINS AND SUPPLEMENTS

AquADEK _____ per day
ADEK tablets_____ per day
Multivitamin & Vitamin E 400IU_____ per day
Ensure/Scandishake/Resource _____ per day
Other:_____

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 one, 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

_____
_____
_____
_____
_____

PHYSIOTHERAPY

Type: PEP Chest Percussion Vest

Frequency: _____x per day