LONDON HEALTH SCIENCES CENTRE
CYSTIC FIBROSIS ADULT CLINIC

PATIENT REPORT AND REVIEW

NAME: _____ **DATE OF VISIT:** _____

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

Height:_____

Date of last clinic visit: _____

Weight:_____

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):	No	Yes
2.	Attended other clinics / doctors' appointments:	No	Yes
3.	Had additional treatments / tests	No	Yes
4.	Had consultation / referral to other health agencies:	No	Yes

If you have answered **Yes** to any of the above, please give details below:

_____

_____

_____

_____

INFECTION CONTROL MEASURES WHILE IN CLINIC

It is recommended that when in the hospital you practice good infection control measures such as hand washing with the available hand sanitizers. When in ANY waiting area, please take whatever measures possible to stay at least 3 feet apart from other CF patients and note that emerging evidence suggests 6 feet is optimal. Although you may not know those around you that have CF, on a CF clinic day it is reasonable to maintain this rule from all others, particularly in smaller spaces such as the Pulmonary Function Lab area. You may have to wait outside of the waiting area at times to maintain this distance.

We realize this may be an inconvenience, but are keenly interested in maintaining the highest standards of infection control. If you have any further concerns or suggestions to improve infection control, please share them with the team.

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, typical frequency: Less than once a week
More than once a week
Daily
Only with therapy

Typical type: Dry
Loose

Change since last visit: Less
Same
More

Sputum: No Yes

If Yes: Amount: Small
Moderate
Large

Change since last visit: Less
Same
More

Colour: Clear
Yellow
Green
Brown

Consistency: Thick
Thin

Blood streaking: No
Occasional
Frequent

Blood (hemoptysis): No Yes

If yes, how many times: _____

Amount: Trace
1 tbsp
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

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

NOSE AND SINUS:

Nose and Sinus Symptoms: No Yes

If yes: Discharge: Clear
Yellow
Green

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

Change since last visit: Better
Same
Worse

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 (if any): Food
Not enough enzymes
Other: _____

Relievers (if any): _____

Where: Upper
Central
Lower
Flank(s)

Nature: Crampy
Sharp
Steady

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) : _

I would like to learn more about: Transplantation: ___ Osteoporosis: ___ Fertility/Sexuality: ___ CF related diabetes (CFRD): ___ Distal Intestinal Obstruction Syndrome (DIOS): ___ Dealing with an employer: ___ Disability Benefits: ____ Living Wills: ___ Disability Tax Credit: ____ Registered Disability Savings Plan:____ Drug insurance Plans: ____	I have had my yearly flu shot ____ Any exposure to cigarette smoke? _____ I perform regular cleaning (after each use - soap & water) and sterilizing (daily boiling x 10 min.) of nebulizer (just mouthpiece not the tube)____ I know to replace nebulizer every 6 months____ I know that there is funding available to help replace compressors (ADP form-ask nurse) ____ **Your main compressor shouldn't be a portable one, they are not built for that purpose** <u>CF related Diabetes Monitoring:</u> I have had my yearly OGTT test ____ Blood sugar monitoring (if applicable): I check my blood sugar: Before meals ___recent levels_____ 2 hrs after meals ___ recent levels_____ Only when sick ___ recent levels _____ Recent blood sugar lows ____

Medication List

Enzymes:

Cotazym ECS 8 / 20 Quantity _____per meals
Ultrase 12 / 20 / 25 _____per snack
Creon 10 / 25 Other _____

Vitamins, Minerals & Supplements:

Centrum Forte + separate A, D, E Quantity_____ Frequency_____
Aquadek Quantity_____ Frequency_____
Vitamin K Quantity_____ Frequency_____
Other MultiVitamins_____ Quantity_____ Frequency_____
Ferrous Sulphate (iron) Quantity_____ Frequency_____
Vitamin D 400/ 1000 / other Quantity_____ Frequency_____
Calcium 500 mg/other Quantity_____ Frequency_____
Scandishake / Ensure Plus / Boost Plus / Ensure / Ensure High Protein / Boost / Resource 2.0 /
Boost Pudding Quantity_____ Frequency_____
Other vitamin, mineral or nutrition product
_____ Quantity _____ Frequency_____

Inhalation Therapy:

Salbutamol (Ventolin) Dose 2.5 mg **or** 5 mg Frequency_____
Tobramycin Dose 80mg X 2 vials Frequency_____
TOBI Dose 300mg Frequency _____
TOBI PODHALER Dose 112 mg (4 tabs) Frequency _____
Pulmozyme Dose 2.5mg Frequency once per day
Hypertonic Saline Dose_____ Frequency_____
Other: _____ Dose _____ Frequency_____

Chest Physiotherapy:

PEP Chest Percussion Other _____ Frequency_____

Other CF medications:

Azithromycin (Zithromax) Dose _____ Frequency_____
Antibiotic pills Dose_____ Frequency_____

Asthma/Sinus Therapy:

Salbutamol (Ventolin) puffer Dose _____ Frequency _____
Symbicort Dose _____ Frequency _____
Advair Dose _____ Frequency _____
Nasal spray Dose _____ Frequency _____
Sinus rinse Dose _____ Frequency _____

Gastrointestinal (Stomach) medications:

PEG 3350 (Lax-a day) Dose _____ Frequency_____
Other: _____ Dose _____ Frequency_____

Other Medications:

	Name(s)	Dose	Frequency	Dates Taken
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____