PCD Follow-Up Form

12 to 18 Years

Name: ______________________

DOB: ______________________

We will use these questions to help plan for your child's upcoming visit and to make sure we try to meet your needs. Thank you for taking the time to answer these questions.

What would you like to discuss at your visit?

____

____

____

Quality of Life (since your last visit)

In general, would you say your quality of life is:
□ Excellent □ Very good □ Good
□ Fair □ Poor

In general, how would you rate your physical health?
□ Excellent □ Very good □ Good
□ Fair □ Poor

How often do you feel really sad?
□ Never □ Rarely □ Sometimes
□ Often □ Always

Pulmonary Review (since your last visit)

Have you experienced a yellow zone or red zone illness?
□ Yes □ No

Did you have difficulty breathing or shortness of breath?
□ No difficulty □ A little difficulty □ Some difficulty
□ A good deal of difficulty □ A great deal of difficulty

How was your cough?
□ No cough □ Slightly better □ Same
□ Very bad □ Extremely bad

How often have you woken up during the night because you were coughing?
□ Never □ Sometimes □ Often □ Always

How much mucus do you cough up per day?
□ No mucus □ A little mucus □ Some mucus
□ A good deal mucus □ A great deal mucus

What color was your sputum?
□ Clear / white □ Yellow □ Green □ Gray
□ Brown □ Does not apply

Did you cough up any blood?
□ No □ Yes, streaked □ Yes, teaspoon
□ Yes, more than a teaspoon

Did you have any chest tightness or wheezing?
□ No tightness or wheezing
□ A little tightness or wheezing
□ Some tightness or wheezing
□ A good deal tightness or wheezing
□ A great deal tightness or wheezing

Do you ever have days when you can't fit in all the Airway Clearance therapies?
□ No □ Yes

Ear and Sinus Review (since your last visit)

How often do you experience sinus symptoms?

□ Never □ Sometimes □ Often □ Always

Have you experienced?
□ headaches
□ facial pain or pressure
□ tooth pain
□ sore throat
□ foul smelling breath

Have you had sinus surgery since your last appt?

□ Yes, if so when: ______ □ No

How frequent do you experience ear symptoms?

□ Never □ Sometimes □ Often □ Always

Ear drainage occurs how often?

□ Never □ Sometimes □ Constant

Have you experienced hearing loss since your last appt?

□ Yes □ No

Have you had ear surgery since your last appt?

□ Yes, if so when: _______ □ No

Continued on back…

Other Health Areas (since your last visit)

How much have you exercised?
□ Every day □ Most days □ Occasionally □ Rare □ None

Have you had difficulty sleeping?
□ No difficulty □ A little difficulty
□ Some difficulty □ A good deal of difficulty
□ A great deal of difficulty

Have you had difficulty keeping up with workload or daily activities?
□ No □ Rarely □ Occasionally
□ Most days □ Every day

How tired did you feel?
□ Not tired □ A little tired □ Somewhat tired
□ A good deal tired □ A great deal tired

Did you feel feverish?
□ No fevers □ A little feverish
□ Somewhat feverish □ A good deal feverish
□ A great deal feverish

How would you rate your pain on average? (0 = no pain, 10 = worst pain imaginable)
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5
□ 6 □ 7 □ 8 □ 9 □ 10

Impact of PCD on Your Life

(Please answer since the last time you saw your PCD team)

How satisfied are you that your efforts to manage your PCD have helped you to do what you want to do in your everyday life?
□ Very satisfied □ Satisfied
□ Neither satisfied or dissatisfied □ Dissatisfied
□ Very dissatisfied

How frequently has PCD symptoms or treatments prevented your child from being able to do what he or she wants to do in everyday life?
□ Never □ Once in a while □ Some of the time
□ Most of the time □ All of the time

Have you experienced increased anxiety, depression or other mental health concerns due to PCD symptoms and care management?
□ Never □ Once in a while
□ Some of the time □ Most of the time
□ All of the time

Medications

Are you confident about your ability to take your medication correctly?
□ Very confident □ Somewhat confident □ Not confident

Have you had any problems obtaining your medications?
□ Yes □ No

Concerns and Requests

What requests to the care team do you have for this visit? (Select all that apply)

Health System
□ Lab Results □ Medication/side effects
□ Research studies □ Travel or school letter
□ Information on patient prescription programs □ Transition of care
□ Airway clearance equipment
□ Refills

My Health
□ Lingering cough □ Abdominal pain
□ Bloody sputum □ Chest pain
□ Change in lung function
□ Recurrent infections
□ Mental Health

Reproductive Health
□ Birth control options
□ Pregnancy / fertility
□ Sexual functioning (coughing during sex; pain with vaginal penetration)
□ Urinary incontinence
□ Yeast infections
□ Puberty

Other Concerns or Requests
□ School concerns □ Financial concerns
□ Insurance concerns □ Other (describe):_________________
□ No concerns or requests
____
____

Click to Submit

**NOTE: By submitting this document to Children's Respiratory & Critical Care Specialists, you are providing implied consent that you understand the risks of sending personal health information in a non-secure email format.*