PCD Follow-Up Form

Birth to 11 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 child's 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 child's quality of life is:
□ Excellent □ Very good □ Good
□ Fair □ Poor

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

How often does your child feel really sad?
□ Never □ Rarely □ Sometimes
□ Often □ Always

Pulmonary Review (since your last visit)

Has your child experienced a yellow zone or red zone illness?
□ Yes □ No

Did your child breathe faster than usual?
□ None of the time □ Some of the time
□ Much of the time □ Don't know

Did your child wheeze/rattle (whistling sound in the chest)?
□ None of the time □ Some of the time
□ Much of the time □ Don't know

Did your child have a wet or mucousy (congested) sounding cough, increased from their baseline?
□ None of the time □ Some of the time
□ Much of the time □ Don't know

Did your child wake up from sleep because of coughing?
□ No □ Yes □ Don't know

Did your child cough to the point of throwing up?
□ No □ Yes □ Don't know

Did your child have one or more coughing "fits" (coughed for a long period of time)?
□ No □ Yes □ Don't know

Did your child show signs or complain of chest pain?
□ No □ Yes □ Don't know

Has your child coughed up (or suctioned out) anything? If yes, what color?
□ No □ Yes, Clear □ Yes, Yellow
□ Yes, Green □ Yes, Red □ Yes, Brown

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 does your child experience sinus symptoms?

□ Never □ Sometimes □ Often □ Always

Has your child experienced?
□ headaches □ facial pain or pressure
□ tooth pain □ sore throat
□ foul smelling breath

Has your child had sinus surgery since the last appt?

□ Yes, if so when: _____ □ No

How frequent does your child experience ear symptoms?

□ Never □ Sometimes □ Often □ Always

Ear drainage occurs how often?

□ Never □ Sometimes □ Constant

Has your experienced hearing loss since the last appt?

□ Yes □ No

Has your child had ear surgery since the last appt?

□ Yes, if so when: _____ □ No

Continued on back...

Other Health Areas (since your last visit)

How much has your child exercised?
□ Every day □ Most days □ Occasionally
□ Rarely □ Not at all

Was your child able to play-run, jump, and climb-as they wanted?
□ Every day □ Most days □ Occasionally
□ Rarely □ Not at all

Did your child sleep more than usual?
□ None of the time □ Some of the time
□ Much of the time □ Don't know

Was your child less active than usual?
□ None of the time □ Some of the time
□ Much of the time □ Don't know

How would you rate your child's 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 Child's Life
(Please answer since the last time you saw your PCD Team)

How satisfied are you that your efforts to manage your child's PCD have helped your child to live a normal 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

Has your child 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 give your child his or her medications correctly?
□ Very confident □ Somewhat confident
□ Not confident

Have you had any problems obtaining your child's 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
□ Research studies
□ Information on patient prescription programs
□ Medication/side effects
□ Travel or school letter
□ Refills
□ Airway clearance equipment

My Child's Health
□ Cough
□ Chest pain
□ Lung function/breathing
□ Mental health
□ Abdominal symptoms or problems
□ Weight / nutrition
□ Recurrent Infections

Other requests / concerns
□ School concerns
□ Insurance concerns
□ No requests / concerns
□ Financial concerns
□ Other:_____
_____

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.*