Cystic Fibrosis 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 (Please answer based on the past 7 days)

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 (Please answer based on the past 7 days)

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

Have you had sinus pain, pressure, and/or congestion?
□ Never □ Sometimes □ Often □ Always

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

Abdominal / GI Review (Please answer based on the past 7 days)

On average, how many stools did you have per day?
□ 0-1 □ 2-3 □ 4-5 □ 6+

In general, what is the consistency of your stool? (Check all that apply)
□ Normal / formed stool □ Fatty / greasy stool
□ Loose or watery stool □ Blood in stool or dark black stool
□ Floating stool □ Hard stool

Have you experienced…? (Check all that apply)
□ Fewer than 3 bowel movements in last 7 days
□ Straining
□ Lumpy or hard stools
□ Passing a very small stool
□ Pain when passing stools

Have you had problems with stomach aches, bloating, feeling full, nausea or vomiting?
□ Always □ Often □ Sometimes □ Never

Have you passed gas more than usual?
□ Yes, a lot more than usual □ Yes, a little more than usual
□ No

How often have you had acid reflux or heartburn?
□ Always □ Often □ Sometimes □ Never

Urinary Review (Please answer based on the past 7 days)

Have you had pain with urination?
□ Always □ Often □ Sometimes □ Never

Continued on back…

Do you have episodes of frequent urination?
□ Always □ Often □ Sometimes □ Never

Have you experienced urinary incontinence (leakage of urine)?
□ Always □ Often □ Sometimes □ Never

Have you had increased thirst? □ Yes □ No

Nutrition Review (Please answer based on the past 7 days)

My appetite was:
□ Excellent □ Good □ Fair □ Poor

I have forced myself to eat.
□ Always □ Often □ Sometimes □ Never

How often have you forgotten or decided not to take your enzymes?
□ Always □ Often □ Sometimes □ Never

Other Health Areas (Please answer based on the past 7 days)

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

If you are diabetic, morning glucose range for past 7 days:
(please indicate value)
Lowest value past 7 days: _________
Highest value past 7 days: _________

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 CF on Your Life
(Please answer since the last time you saw your CF team)

How satisfied are you that your efforts to manage your CF 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 have CF-related symptoms prevented you from being able to do what you want to do in your everyday life?
□ Never □ Once in a while □ Some of the time
□ Most of the time □ All of the time

How frequently have CF daily care / treatments prevented you from being able to do what you want to do in your everyday life?
□ Never □ Once in a while □ Some of the time
□ Most of the time □ All of the time

Medications (Please answer based on the past 7 days)

Are you confident about your ability to take your medication correctly?
□ Very confident □ Somewhat confident □ Slightly 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 letter
□ Information on patient prescription programs □ Transition of care
□ Refills

My Health
□ Lingering cough □ Abdominal pain
□ Bloody sputum □ Chest pain
□ Weight gain □ Change in lung function
□ CF related diabetes □ Recurrent infections
□ Coping with CF

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
____
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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.*