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

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 (Please answer based on the past 7 days)

Did your child breathe faster than usual?
□ None of the time (0 days)
□ Some of the time (1-4 days)
□ Much of the time (5-7 days)
□ Don't know

Did your child wheeze (whistling sound in the chest)?
□ None of the time (0 days)
□ Some of the time (1-4 days)
□ Much of the time (5-7 days)
□ Don't know

Did your child have a wet or mucousy (congested) sounding cough?
□ None of the time (0 days)
□ Some of the time (1-4 days)
□ Much of the time (5-7 days)
□ 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

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+

Was your child's poop larger than usual?
□ No
□ Yes
□ Don't know

Did your child's poop look oily?
□ No □ Yes, a little oily
□ Yes, a lot oily □ Don't know

Did your child pass gas more than usual?
□ No □ Yes, a little more gas
□ Yes, a lot more gas □ Don't know

Did your child's stomach appear larger and/or firmer than usual?
□ No □ Yes, a little larger or firmer
□ Yes, a lot larger or firmer □ Don't know

Did your child show signs of stomach pain?
□ No □ Yes □ Don't know

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

My child's appetite was:
□ Excellent □ Good □ Fair □ Poor

Did your child eat less than usual?
□ None of the time (0 days) □ Some of the time (1-4 days)
□ Much of the time (5-7 days)□ Don't know

Continued on back…

Did your child spit up or vomit after eating?
□ No □ Yes, spit up a little
□ Yes, spit up a lot □ Don't know

Has your child eaten a meal or snack without taking enzymes?
□ Always □ Often □ Sometimes
□ Never □ Not applicable

Mealtime is unpleasant or stressful.
□ Always □ Often □ Sometimes □ Never

I forced my child to eat.
□ Always □ Often □ Sometimes □ Never

I felt confident in managing my child's behavior at mealtime.
□ Always □ Often □ Sometimes □ Never

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

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 (0 days) □ Some of the time (1-4 days)
□ Much of the time (5-7 days) □ Don't know

Did your child have a fever?
□ No □ Yes □ Don't know

Did your child have a stuffy nose?
□ No □ Yes □ Don't know

Was your child less active than usual?
□ None of the time (0 days) □ Some of the time (1-4 days)
□ Much of the time (5-7 days) □ 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 CF on Your Child's Life
(Please answer since the last time you saw your CF Team)

How satisfied are you that your efforts to manage your child's CF have helped your child to live a normal life?
□ Very satisfied
□ Satisfied
□ Neither satisfied or dissatisfied
□ Dissatisfied
□ Very dissatisfied

How frequently has your child's CF daily care / 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

How frequently has your child's CF-related symptoms 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

Medications (Please answer based on the past 7 days)

Are you confident about your ability to give your child his or her medications correctly?
□ Very confident □ Somewhat confident
□ Slightly 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 □ Medication/side effects
□ Research studies □ Travel letter
□ Information on patient prescription programs □ Refills

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

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

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.*