Michigan State University Cystic Fibrosis Clinic Interval History

Name: __________________________ Date of Birth ______________ Visit Date: ____________ Form completed by: __________

Clinic use only: MRN _______________________ **Reviewed by:** _______________________

History since your last appointment in Cystic Fibrosis Clinic:

GENERAL:

- ❑ Fevers, chills or sweats
- ❑ Change in appetite
- ❑ Sleep problems
- ❑ Tiredness
- ❑ Dental problems
- ❑ **NONE**

EYES:

- ❑ Discharge or drainage
- ❑ Redness/injury
- ❑ Vision change/problem
- ❑ Yellowing
- ❑ Cataracts
- ❑ **NONE**

CARDIOVASCULAR:

- ❑ Chest pain
- ❑ Fainting or lightheadedness
- ❑ Cyanosis (bluish color to skin)
- ❑ Activity intolerance
- ❑ Palpitations/abnormal heartbeat
- ❑ **NONE**

URINARY/GENITALIA:

- ❑ Painful urination
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Swelling or redness
- ❑ Involuntary urination or bedwetting
- ❑ **NONE**

MUSCULOSKELETAL:

- ❑ Joint pain or stiffness
- ❑ Joint swelling
- ❑ Broken bones or other injury
- ❑ Osteopenia/Osteoporosis
- ❑ **NONE**

SKIN:

- ❑ Rash, redness or itching
- ❑ Acne
- ❑ Eczema/psoriasis
- ❑ Nail/hair changes
- ❑ **NONE**

ALLERGY:

- ❑ Hives
- ❑ Itchy eyes, nose, or throat
- ❑ New medication or food allergy
- ❑ **NONE**

NEUROLOGICAL:

- ❑ Seizures/convulsions
- ❑ Dizziness/vertigo
- ❑ Headaches
- ❑ Poor coordination
- ❑ Speech problems
- ❑ Ringing in ears
- ❑ **NONE**

PSYCHOLOGICAL:

- ❑ Depressed, anxious or irritable
- ❑ Hyperactive and/or ADHD
- ❑ Problems in school, daycare, work
- ❑ **NONE**

ENDOCRINE:

- ❑ Cold or heat intolerance
- ❑ Excessive thirst/urination
- ❑ Excessive hunger
- ❑ Poor growth/weight changes
- ❑ Diabetes
- ❑ **NONE**

BLOOD/LYMPHATIC:

- ❑ Prolonged bleeding
- ❑ Big lymph nodes/swollen glands
- ❑ Paleness
- ❑ Nosebleeds
- ❑ **NONE**

GASTROINTESTINAL

- ❑ Reflux
- ❑ Nausea
- ❑ Greasy/Oily stools
- ❑ Bloating
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Jaundice
- ❑ **NONE**

APPETITE/INTAKE:

❑ Good ❑ Fair ❑ Poor

NUTRITIONAL SUPPLEMENTS:

- ❑ Formula /supplement type ________________________
- ❑ Amount per day ________________________

❑ Mouth ❑ G-Tube

ENZYMES:

- ❑ Within 30 min before meal
- ❑ Immediately before meal
- ❑ During meal
- ❑ Immediately after meal
- ❑ Within 30 min after meal

In a usual week, how often do you miss your enzymes:

❑ None ❑ 1–3 ❑ 4 or more

EARS, NOSE, & THROAT:

- ❑ Ear pain, discharge or drainage
- ❑ Decreased hearing
- ❑ Nasal congestion
- ❑ Chronic mouth breathing
- ❑ Sore throat
- ❑ Difficulty swallowing
- ❑ Sinus pressure
- ❑ Sneezing – itchy nose
- ❑ Pain in forehead—headaches
- ❑ Nose bleeds
- ❑ Polyps
- ❑ **NONE**

SLEEP:

- ❑ Snoring
- ❑ Restless during sleep
- ❑ Daytime sleepiness
- ❑ Morning headaches
- ❑ Chronic mouth breathing
- ❑ **NONE**

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COUGH:

- ❑ Occasional
- ❑ Only with airway clearance
- ❑ Daily
- ❑ Cough that interferes with sleep
- ❑ Cough that interferes with activities
- ❑ **NONE**

SPUTUM COLOR:

- ❑ Tan
- ❑ Yellow
- ❑ Green
- ❑ White
- ❑ Bloody
- ❑ Clear
- ❑ **NONE**

SPUTUM AMOUNT:

- ❑ Teaspoon
- ❑ Tablespoon
- ❑ **NONE**

SPUTUM PRODUCTION:

- ❑ Increase
- ❑ Decrease
- ❑ **NO CHANGE**

CHEST CONGESTION

❑ No ❑ Yes

COLDS SINCE LAST VISIT:

- ❑ **NONE**
- ❑ Yes How many? _______

ANTIBIOTICS SINCE LAST VISIT:

- ❑ **NONE**
- ❑ Yes # of times _______

INHALED MEDICATIONS:

- ❑ Albuterol
- ❑ Hypertonic Saline
- ❑ Pulmozyme
- ❑ Tobramycin
- ❑ Other: ______________________
- ❑ **NONE**

PRIMARY AIRWAY CLEARANCE:

- ❑ Chest Vest
- ❑ Chest PT
- ❑ Acapella/Aerobika
- ❑ Active Cycle of Breathing
- ❑ Exercise

Times per day______________

Minutes per treatment_________

SECONDARY AIRWAY CLEARANCE:

- ❑ Chest Vest
- ❑ Chest PT
- ❑ Acapella/Aerobika
- ❑ Active Cycle of Breathing
- ❑ Exercise

Times per day___________________

Minutes per treatment______________

DURING TIMES OF RESPIRATORY ILLNESS: (check all that apply)

- ❑ Increase vest treatments
- ❑ Increase albuterol/Xopenex
- ❑ Add secondary airway clearance
- ❑ **NONE**

CLEANING EQUIPMENT:

- ❑ Daily
- ❑ Weekly
- ❑ Rarely

STERILIZING EQUIPMENT:

- ❑ Boil
- ❑ Dishwasher
- ❑ Other: ____________________

Frequency: ____________________

HOME OXYGEN:

- ❑ Continuous
- ❑ Nighttime
- ❑ CPAP
- ❑ BIPAP
- ❑ **NONE**

Liters per minute __________

PAP Settings______________

VISITS TO ANOTHER SPECIALIST:

- ❑ ENT
- ❑ GI
- ❑ Endocrinology
- ❑ Other: ________________________

Why:_____________________________

____

IMMUNIZATIONS:

Are immunizations up to date?
❑ No ❑ Yes

Yearly flu vaccine?
❑ No ❑ Yes

COVID vaccine?
❑ No ❑ Yes

SOCIAL/FAMILY:(does anyone in your household use any of the following)

- ❑ Cigarettes/cigars/pipes
- ❑ Vape/E-cig
- ❑ Marijuana
- ❑ Other Substance: ________________
- ❑ **NONE**

If yes, then who________________

Are you exposed to any secondhand smoke?

- ❑ Daily
- ❑ Weekly
- ❑ Rarely
- ❑ **NEVER**

SCHOOL: (if applicable)

❑ Public ❑ Private ❑ home

Grade level _____

Preschool ❑
Daycare ❑
Babysitter ❑

Days per week__________

Children present ________

SCHOOL/WORK ABSENCES
Days missed for Breathing Problems since last visit _________________

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FAMILY CHANGES:

- ❑ Marriage
- ❑ Separation
- ❑ Move
- ❑ Death in family
- ❑ Divorce
- ❑ Birth
- ❑ Change in school/work
- ❑ Loss of job
- ❑ Change in income
- ❑ Change in insurance
- ❑ Other ______________________

PSYCHOSOCIAL CONCERNS:

- ❑ Marriage
- ❑ Changes in mood
- ❑ Increase anxiety
- ❑ Anger
- ❑ Suicidal thoughts
- ❑ Difficulty completing tasks
- ❑ Feeling helpless/hopeless
- ❑ Treatment adherence
- ❑ Change in school/work performance
- ❑ Other_________________________

____

____

FOOD SECURITY

Within the past 12 months we worried our food would run out before we had money to buy more:

- ❑ Often True
- ❑ Sometimes True
- ❑ Never True
- ❑ Unsure

Within the past 12 months the food we bought just didn't last and we didn't have money to buy more:

- ❑ Often True
- ❑ Sometimes True
- ❑ Never True
- ❑ Unsure

YEAR OF LAST EYE EXAM

____

Do you need any refills on medications? ____

Are you having any problems with your equipment? Do you need any new supplies? _______________________

____

Pharmacy name: ____

Medical Supply Company: ____

Please rate your overall well-being: 1 2 3 4 5 6 7 8 9 10
POOR EXCELLENT

Concerns you would like to discuss____

What is your goal for this clinic visit? ____

____

____

____

What can we help you learn about managing cystic fibrosis? ____

____

____

____

Signature of person completing form Date

____

Relationship to patient