Hartford Hospital
A Hartford HealthCare Partner

571053

Central Connecticut Cystic Fibrosis Center

Name: _____/DOB:_____ Date:_____

My primary health concern or issue I wish to address during today's clinic is:

_____

Medication List:

Respiratory Care:	Albuterol (nebulizer or MDI with spacer) ___times/day Xopenex___ mg _____ times/day nebulizer Hypertonic Saline: ___ mls ___ times/day Pulmozyme: ___ vials ____ times/day Flovent: 110_____times/day 220_____ times/day Advair: 100/50__ 250/50__ 500/50__ clicks___ times/day ___ Pulmicort: ___ puffs ___ times/day
Antibiotics:	Oral: _____ times/day for ____days _____ times/day for ____ days Inhaled: _____ times/day for _____ days _____ times/day for _____ days
Diabetes medication:	Insulin: _____ dose (ie: sliding scale, CHO counted) _____ dose Oral: _____ dose
Other medications:	_____ _____ _____

Do you need any pharmacy refills? 30 day_____ 90 day _____

Nutrition:

Appetite:	Great___ Good___ Fair___ Poor___
Vitamins:	ADEK ____/d OTC MVT ____/d Vit D ____/d/wk Vit C ____/d Vit A ____/d Vit K ____/d Vit E ____/d Other_____
Enzymes:	Brand: _____ Dose: _____/meal and _____/snack
GI Medications:	Uros/Actigal:_____ Reflux/stomach: _____ Anti-nausea/motility: _____
Appetite stimulant:	Yes/No Brand/frequency: _____
Supplements/Tube feeding:	Boost/Ensure/Scandishakes/other: _____ cans/day Tube feeding: _____ cans/day (bolus/pump)
Herbals Medications:	

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Social Work:

Any changes in the following, please specify:	Amount/source of income? No ___ Yes___
	Medical coverage/insurance? No___ Yes___
	Living situation? No___ Yes___
	General emotional/social situation? No___ Yes ___

Are you enrolled in any medication incentive and/or assistance programs? No___ Yes ___
Please list: _____
_____

Sputum	Amount per day:	None___ 1 tsp ___ 1 TBSP ¼ cup ___ more than ¼ cup ___	
	Change from normal?	No ___ Increased ___ Decreased ___	
	Color:	White___ Yellow ___ Green ___ Brown ___ Blood Tinged ___	
Airway Clearance (check as many as apply)	**Type**	**# of times/day**	**# of days/week**
	Vest		
	Acapella		
	Active Cycle of Breathing		
	Autogenic Drainage		
	Chest PT/postural drainage		
	Other:		
Exercise			

Respiratory:

Who is your DME provider? _____

What is your sick day plan:
_____
_____
_____
_____