|  |
| --- |
| Name or ID |

Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_\_\_\_ (dd/mm/yy)

Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Weight \_\_\_\_\_ kg/ change \_\_\_\_ kg/ P\_\_\_\_\_Length \_\_\_\_\_ cm/ change \_\_\_\_ kg/ P\_\_\_\_\_Respiratory rate \_\_\_\_\_/minHeart rate \_\_\_\_\_/minRR \_\_\_\_\_/\_\_\_\_\_ mmHg O2 saturation \_\_\_\_\_/%Need of O2 O no O yes \_\_\_ l/min5 min without O2 Saturation \_\_\_\_\_ %  |

**History since last visit**

 Pulmonary exacerbation O no O yes (if yes use extra sheet EXACERBATION)

|  |
| --- |
| Dyspnoea O no O yes Start: \_\_\_/\_\_\_\_Tachypnea O no O yes Start: \_\_\_/\_\_\_\_Cough O no O yes Start: \_\_\_/\_\_\_\_Retractions O no O yes Start: \_\_\_/\_\_\_\_Hemoptysis O no O yes Start: \_\_\_/\_\_\_\_Gastroesophageal reflux O no O yes Start: \_\_\_/\_\_\_\_Recurrent aspirations O no O yes Start: \_\_\_/\_\_\_\_ |

|  |
| --- |
| **Medication** (if more than 3 use extra sheet MEDICATION) |

|  |
| --- |
| Fan 5 point severity scaleO AsymptomaticO Symptomatic, normal room air oxygen saturation under all conditionsO Symptomatic, normal resting room air saturation, but abnormal saturation (< 90%) with sleep or exerciseO Symptomatic, abnormal resting room air saturationO Symptomatic with pulmonary hypertension |

|  |  |
| --- | --- |
| Physician’s opinion: “The course of disease is…” | o healthyo sick-bettero sick-sameo sick-worseo dead |
| Patient´s/Parent’s opinion:“How do you feel? Please give a number from 1 (“very bad”) to 10 (“fine”).” | \_\_\_\_\_ (1-10) |

**Examination findings Vaccinations** O no O yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **New comorbidities** O no O yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnostics** (use extra sheet DIAGNOSTICS)

**Plan/ changes in medication/ next visit**