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

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

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

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

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

|  |
| --- |
| Weight \_\_\_\_\_ kg/ change \_\_\_\_ kg/ P\_\_\_\_\_  Length \_\_\_\_\_ cm/ change \_\_\_\_ kg/ P\_\_\_\_\_  Respiratory rate \_\_\_\_\_/min  Heart rate \_\_\_\_\_/min  RR \_\_\_\_\_/\_\_\_\_\_ mmHg O2 saturation \_\_\_\_\_/%  Need of O2 O no O yes \_\_\_ l/min  5 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) |

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| --- |
| Fan 5 point severity scale  O Asymptomatic  O Symptomatic, normal room air oxygen saturation under all conditions  O Symptomatic, normal resting room air saturation, but abnormal saturation (< 90%) with sleep or exercise  O Symptomatic, abnormal resting room air saturation  O Symptomatic with pulmonary hypertension |

|  |  |  |
| --- | --- | --- |
| Physician’s opinion:  “The course of disease is…” | o healthy  o sick-better  o sick-same  o sick-worse  o 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**