Patient Label

National Jewish Health®
Science Transforming Life®

Pulmonary/ILD Follow Up Visit Questionnaire

		Yes	No	Explanation
1)	Have you had any emergency room visits or hospitalizations in the last 12 months? If so, please tell us where, when, and what happened.	☐	☐	_____
2)	Have you taken any oral steroids or antibiotics in the last 12 months? If so, please tell us when, what you took, and why.	☐	☐	_____
3)	Have your other doctors identified any new diagnoses or medical problems since your last visit? If so, please describe.	☐	☐	_____
4)	Did you have any medical procedures, surgeries, radiologic studies or outside test results since your last visit? If so, please let us know what you had and the results.	☐	☐	_____

5) How much oxygen do you use at rest_____ with sleep_____ with activity_____

6) Do you use CPAP (Y/N)?_____ If so, what are the pressure settings_____

7) What is your daily activity level or exercise regimen? _____

_____

Physician Only:

Number of exacerbations in the last 12 months:

☐

Asthma COPD ILD Bronchiectasis

Initials _____

8) What questions do you want the doctor to address today?

_____

_____

_____

_____

9) **Are you experiencing any of the following symptoms?** (please **circle** all that apply—all items **not** circled are negative)

Fever	Chest Pain	Numbness
Chills	Palpitations	Weakness or tingling in any part of body
Night Sweats	Swelling in feet or legs	Blood in the urine
Loss of appetite	Nausea	Pain with urination
Difficult speech or swallowing	Vomiting	Increased urinary frequency at night
Hoarseness	Abdominal pain	Rash
Congestion	Heartburn	Hives
Runny nose	Weight change	Other changes in the skin
Change in voice	Blood in stool	Bleeding
Cough	Joint pain	Blood cots
Sputum production	Joint swelling	Easy bruising
Shortness of breath at rest	Muscle pain	Anxiety
Shortness of breath with exercise	Muscle tenderness	Depression
Coughing up blood	Difficulty with balance	None of the above

Other _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____

(OVER)

Enter Name _____ Today's Date: _____

MRN _____ Patient's Name: _____

_____

FOR PATIENTS:

Take the Asthma Control Test™ (ACT) for people 12 yrs and older.

Know your score. Share your results with your doctor.

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for your total.

Step 3 Take the test to the doctor to talk about your score.

									SCORE
1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?	All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5	
2. During the past **4 weeks**, how often have you had shortness of breath?	More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5	
3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	4 or more nights a week	1	2 or 3 nights a week	2	Once a week	3	Once or twice	4	Not at all	5	
4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	3 or more times per day	1	1 or 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5	
5. How would you rate your **asthma** control during the **past 4 weeks**?	Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5	
											TOTAL

If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.

FOR PHYSICIANS:

The ACT is:

- A simple, 5-question tool that is self-administered by the patient
- Clinically validated by specialist assessment and spirometry[1]
- Recognized by the National Institutes of Health

NSG 401 (6/15)

Reference: 1. Nathan RA et al. *J Allergy Clin Immunol.* 2004;113:59-65.