Patient Questionnaire (For Underlying Bronchiectasis)

Date of Assessment: ________

Patient Name: ______________________________ Physicians Name _________________________________

Circle one for all those that apply for the questions below

1.) Have you been diagnosed with Bronchiectasis? Yes No

2.) How many times have you been hospitalized with lung infections in the last year? 1___ 2___ 3___ 4___ 5___

3.) How many times have you been prescribed antibiotics for lung infections in the last year? 1___ 2___ 3___ 4___ 5___

4.) Have you had a CT of your chest in the last 10 years? Yes No

If Yes, where was the CT scan completed? ________________Approximate date of the scan?________

5.) Have you had a persistent productive cough for 6 continuous months? Yes No

6.) Have you tried airway clearance therapy in the past?

- Chest Physical Therapy (CPT) Cupped hand that pat on the chest to thin secretions or sputum Yes No
- Huff Coughing or Postural Drainage Techniques Yes No
- PEP Device (Flutter Valve, Accapella, Aerobika) Yes No

If Yes, have you had another lung infection? Yes No

Additional Comments:
____
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____
____

Name of person completing survey: ____

Relationship to person: ____

Date form completed: ____

Respiratory Therapist who completed phone assessment: _________________________________

Respiratory Therapist Notes:
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Further Recommendations: