



RETURN PATIENT QUESTIONNAIRE

Your Name: *this form can be downloaded at: <http://cfcenter.stanford.edu/acfac/links.html>*

1. List any recent changes in your medications or medical routine (including integrative or alternative therapies). Please especially note the antibiotics you are currently taking and the type of airway clearance and/or exercise you do now.

2. List any symptoms you are experiencing. Please especially note changes in your sputum (color or amount), cough, breathing, sinuses, headaches, digestive habits, appetite, weight, energy level, blood sugars, or temperature.

3. During this clinic visit is there anything specific you'd like to discuss? (For example, do you have recent lab results to go over or need prescription refills? Or, do you want to discuss a visit to another specialist or alternative therapist?)

4. Please list your past diagnoses and/or surgeries (what they were and when). For example, diagnoses of pseudomonas, aspergillus, gastroesophageal reflux, diabetes, arthritis, or sinusitis, and surgeries including g-tube placement, mediport placement, or sinus surgery.