UNC Bronchiectasis/NTM Patient Intake Form

Please complete form as able to make your first visit more productive. A picture is worth a thousand words so please make sure to bring copies of all of your chest imaging on disk or ask the radiology center where imaging was done to mail the disk to our clinic or send images electronically (if capable).

Patient Information

Name	
Preferred Name	
Physicians Involved in Your Care	

Emergency Contact

Name:
Phone:
Relationship:

Reason for Referral (Check all that apply):

☐ Bronchiectasis
☐ Mycobacterial Infection
  ☐Untreated
  ☐Treated with _____ since (dates) _____.
☐ Evaluation for Primary Ciliary Dyskinesia (PCD)
☐ Other _____

Clinical Information:

- Chronic Cough? ☐ yes ☐ no
  - How long has the cough been present? _____
  - Is the cough worse at certain times of the year?_____
  - Is the cough productive? ☐ yes ☐ no
  - Does the cough sound wet? ☐ yes ☐ no
  - Is the cough present daily, year-round? ☐ yes ☐ no
- Wheezing? ☐ yes ☐ no ☐ unknown
- History of pleurisy? ☐ yes ☐ no ☐ unknown
- Have you ever had hemoptysis (coughing up blood)? ☐ yes ☐ no
- Recurrent Bronchitis and/or pneumonia? ☐ yes ☐ no
- On average, how many times per year are you treated with antibiotics for lung infections? _____
- Have you ever been hospitalized for respiratory symptoms or a lung infection? ☐ yes ☐ no
  - If yes, when was the most recent admission and where was it?
    _____

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- Which statement below best describes you?
  - ☐ I get short of breath only if I am strenuously exercising
  - ☐ I get short of breath when I hurry on flat ground or if I'm walking up a slight hill.
  - ☐ I walk slower than others my age because I'm short of breath, or I must stop for breath when walking at my own pace on flat ground for about 15 minutes.
  - ☐ I must stop for breath after walking about 100 meters (about the length of a football field) or a few minutes on flat ground.
  - ☐ I am too breathless to leave the house, or I am breathless when dressing or undressing.

Airway clearance: (check all that apply)

☐ Exercise (What? Frequency?) _____
☐ Percussive Vest (Frequency) _____
☐ Handheld device (flutter, PEP, Acapella, Aerobika) (Frequency?) _____
☐ Chest PT (physical therapy) (Frequency) _____
☐ Nebulized sodium chloride (0.9%, 3%, 7%, 10%) (Frequency) _____
☐ Nebulized acetylcysteine (Frequency) _____
☐ Other _____(Frequency) _____
☐ None

Other Therapies:

☐ Inhaled antibiotics (tobramycin, colistin, amikacin)
☐ Inhalers
☐ Chronic oral antibiotics (azithromycin)
☐ Prednisone

- What is the name of your DME company (who provides your equipment)?_____
- Oxygen use? ☐yes ☐ no
  - If yes, how many liters? _____
  - When is oxygen used? _____
- Have you ever completed a pulmonary rehabilitation program? ☐ yes ☐ no ☐ Unknown

Prior Testing (Circle if done):

- Echocardiogram (ultrasound of heart)
- Alpha-1-antitrypsin testing
- Antibody levels (IgG, IgE, IgM, IgA)
- Allergy testing (Skin or blood)
- Sweat chloride testing for cystic fibrosis
- Cystic fibrosis genetic testing
- GI testing for reflux (pH probe/manometry; endoscopy; barium swallow)
- Sinus imaging
- Sleep study

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Personal Medical History: If you have any of the following, please mark appropriate date of onset.

	Date		Date		Date
Allergic bronchopulmonary aspergillosis (ABPA)		Congenital heart disease (from birth)		Organs are on opposite side from expected	
Allergic rhinitis		Exposure to TB or positive PPD		Pancreatitis	
Allergy shots		Hiatal hernia		Pneumothorax (collapse of lung)	
Asthma		HIV		Recurrent ear infections	
Autoimmune disease		Immune deficiency		Recurrent sinus infections	
Cataracts		Infertility/Difficulty conceiving		Sleep apnea	
Chronic skin condition		Inflammatory bowel disease (Crohn's, ulcerative colitis)		Sarcoidosis	

Surgical History: If you have undergone any of the following surgeries, mark approximate date.

	Date		Date		Date
Bronchoscopy		Lung biopsy		Sinus Surgery	
Ear tube placement		Lung resection		Other _____	
Heart surgery		Nissen fundoplication		Other _____	

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Have you experienced any of the following?

Yes	No	Problems	Yes	No	Problems
		Change in appetite			Night sweats
		Change in energy level			Recurrent fevers
		Chronic nasal congestion			Swelling of your legs
		Difficulty swallowing			Unintentional weight loss of more than 10 pounds in past year
		GERD (reflux)			

Family History: If any blood related family member (parent, sibling, child, aunt, uncle, cousin, etc) has any of the conditions listed below, please list approximate age of onset.

	Father	Mother	Brother	Sister	Child	Other
Asthma						
Autoimmune Disease (specify)						
Bronchiectasis						
Congenital Heart Disease						
COPD						
Cystic Fibrosis (CF)						
Immune Deficiency						
Infertility						
Mycobacterial Infection (NTM)						
Primary Ciliary Dyskinesia (PCD)						
Recurrent Pancreatitis						
Sarcoidosis						

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Social History:

- Smoking/Vaping history: ☐yes ☐ no
  - Current Smoker ☐yes ☐ no
    - If yes, how many packs per day? _____
    - How many years have you smoked? _____
  - Former Smoker ☐yes ☐ no
    - If yes, how many packs per day? _____
    - How many years did you smoke?_____
    - Date quit smoking_____
  - Second hand smoke exposure? ☐yes ☐no
    - Please describe._____
  - Vaping or E-cigarette use? ☐yes ☐no
    - If yes, what product? _____
    - How much each day?_____
    - How long? _____

- Where did you grow up?_____
- What kinds of work have you done?_____

Additional Comments: (Please share any family history information or interesting clinical medical history that would be vital for us to know)

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