# Bronchiectasis Visit Checklist

Bring this completed checklist to your next healthcare appointment.

Name:_____ Date: _____ Healthcare Provider: _____

## How have you been feeling?

Have you experienced any of these symptoms since your last visit? (check all that apply)

- ☐ Frequent coughing
- ☐ Coughing up mucus
- ☐ More mucus than usual
- ☐ Mucus changed color
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Fatigue

## My Mucus

**Color** (check one):
- ☐ Clear
- ☐ Yellow
- ☐ Green
- ☐ Brown
- ☐ Blood-tinged

**Amount:**
- ☐ Small
- ☐ Moderate
- ☐ Large

**Has it changed recently:**
- ☐ Yes ☐ No

## Since my last visit

- ☐ I needed antibiotics.
- ☐ I needed oral steroids.
- ☐ I visited the Emergency Department.
- ☐ I was hospitalized.
- ☐ I missed work, school, or normal activities because of my breathing.

## Medications

Which of the following medications are you currently using? (check all that apply)

- ☐ Nebulized saline
- ☐ Bronchodilator
- ☐ Other: _____

## My Airway Clearance Routine

**How often do you perform airway clearance?**
- ☐ Every day
- ☐ Most days
- ☐ A few times a week
- ☐ Rarely
- ☐ Not currently

**What do you use?**
- ☐ Huff cough
- ☐ Nebulizer
- ☐ PEP device
- ☐ Oscillating PEP
- ☐ Vest therapy therapy
- ☐ Other: _____

**Treatment Time:** _____ Minutes

## What challenges do you have with your current treatment routine?

- ☐ It does not clear enough mucus.
- ☐ It takes too much time.
- ☐ It requires multiple devices or steps.
- ☐ It is difficult to complete consistently.
- ☐ It is uncomfortable or tiring.
- ☐ I need help from another person.
- ☐ Other: _____

## Questions for my healthcare provider

- ☐ Is my current airway-clearance routine adequately managing my mucus burden?
- ☐ Could BiWaze® Clear be appropriate for my bronchiectasis?
- ☐ How would it fit into or replace parts of my current treatment routine?

**Additional Questions:**

_____

_____

***Tracking your symptoms and treatment can help your healthcare team provide the best care possible.***

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