PriMED PHYSICIANS
Treating You Well.®

Asthma Questionnaire 1 – 4 Years

Patient Name: _____Date of Birth: ____/____/____ Date of Visit: ____/____/___

PARENTS: Please complete form. Thank you for helping us care for your child.

1. How many days of school/daycare has your child missed **due to asthma** in the **past 6 months?** ____ # of days ☐ Does not attend
2. How many work days have you or your spouse missed **due to your child's asthma** in the **past 6 months?** ____ # of days ☐ Not currently employed
3. How would you rate your child's asthma control during the **past month**? ☐ Very poorly controlled ☐ Not well controlled ☐ Well controlled
4. How comfortable are you in your ability to manage your child's asthma, rated on a scale of 1-10? (Please circle)

   Not Comfortable = 1 2 3 4 5 6 7 8 9 10 = Very Comfortable

5. Please mark **all** things (triggers) that make your child's **asthma** worse:

   ☐ Respiratory Infections ☐ Irritants (Tobacco Smoke, Wood Smoke, Air Pollution, Perfumes, Incense, Other Irritant)

   ☐ Allergens (Animals, Dust, Pollen, Mold, Food) ☐ Exercise/Increased Activity ☐ Heat/Humidity ☐Cold Air

   Changes in Weather (**Check all** that apply) ☐ Winter ☐ Spring ☐ Summer ☐ Fall ☐ Don't know ☐None

6. For patients who use rescue/controller inhalers, is a spacer utilized? ☐ YES ☐ NO ☐ NOT SURE
7. Is the patient on a controller medication? ☐ YES ☐ NO What Medication? _____
8. If YES, How many missed doses has the patient had in the past 2 weeks? _____
9. Does the patient have a written asthma action plan? ☐ YES ☐ NO
10. Has the patient been seen by an allergist or pulmonologist during the **last 12 months?**

    Specialist: _____ ☐ YES ☐ NO

11. How often has the patient had shortness of breath, wheezing or coughing in the last month?

    ☐ 2 or fewer days per week ☐ More than 2 days per week ☐ Throughout the day

12. How often has the patient awakened in the night due to coughing, wheezing or shortness of breath in the last month?

    ☐ 1 or fewer days per month ☐ More than 1 time per month ☐ More than 1 time a week

13. Has the patient had to limit their play or activities due to asthma in the last month?

    ☐ None ☐ Some limitations ☐ Extremely limited

14. How many times has the patient had to use a quick rescue inhaler or nebulizer in the last month? (includes Albuterol, Ventolin®, Proventil®, Xopenex®)

    ☐ 2 or fewer days a week ☐ More than 2 days a week ☐ Several times each day

15. How many times has the patient had to use oral steroids for an asthma attack in the past year?

    ☐ 0 to 1 times a year ☐ 2 or 3 times a year ☐ More than 3 times a year

Physician Signature: _____