PriMed Physicians
Treating You Well.

Asthma Questionnaire 1 – 4 Years

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

Physician Name: _____ ☐ Asthma well visit ☐ Asthma exacerbation ☐ Asthma exacerbation follow up ☐ Other

PARENT SECTION – Please complete questions 1-19. 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. Has your child visited the Emergency Room or Urgent Care Center **due to asthma** in the **past 12 months?** ☐ YES ☐ NO
   If yes, how many times? _____ **Which Facility?** _____
4. Has your child been admitted to the hospital **due to asthma** in the **past 12 months?** ☐YES ☐NO
   If yes, how many times? _____ **Which Facility?** _____
5. How would you rate your child's asthma control during the **past month**? ☐ Very poorly controlled ☐ Not well controlled ☐ Well controlled
6. 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**
7. 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)
   ☐Changes in Weather ☐Allergens (Animals, Dust, Pollen, Mold, Food) ☐Exercise/Increased Activity ☐Heat/Humidity ☐Cold Air
   ☐Other: _____ ☐ Don't know ☐None
8. When are **asthma** symptoms worse? (**Check all** that apply) ☐ Winter ☐ Spring ☐ Summer ☐ Fall
9. Does asthma or other breathing problems limit activities or play at home? Check all of the following statements that apply.
   ☐ The patient is seldom active ☐ No limit to any activities or play ☐ Performance in sports or play is reduced
   ☐ Sometimes have to *stop* activities or play due to breathing problems ☐ Has to *avoid* activities or play due to breathing problems
   Please describe what activities or play were limited or avoided _____
10. For patients who use rescue/controller inhalers, is a spacer utilized? ☐ YES ☐ NO ☐NOT SURE
11. Is the patient on a controller medication? ☐YES ☐NO If so, what medication? _____
12. If YES, does the patient take his/her controller medicine as prescribed?
    ☐ All of the time ☐ about 75% of the time ☐ About 50% of the time ☐ Less than 50% of the time
13. Does the patient have a written asthma action plan? ☐ YES ☐ NO
14. Has the patient been seen by an allergist or pulmonologist during the **last 12 months?**
    ☐ YES ☐ NO Specialist: _____
15. 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
16. 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
17. Has the patient had to limit their play or activities due to asthma in the last **month?**
    ☐ None ☐ Some limitations ☐ Extremely limited
18. 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
19. 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 SECTION

20. Asthma severity level: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
21. Physician assessment of control: ☐ Well controlled ☐ Not well controlled ☐ Very poorly controlled
22. Has the patient had spirometry in the past 1-2 years?
    ☐ YES: date____/____/____ ☐ NO ☐ Ordered this visit
    ☐ IOS ☐ ENO

Physician Initials _____