

Asthma Questionnaire 5 –11 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:

<input type="checkbox"/> Respiratory Infections	<input type="checkbox"/> Irritants (Tobacco Smoke, Wood Smoke, Air Pollution, Perfumes, Incense, Other Irritant)
<input type="checkbox"/> Changes in Weather	<input type="checkbox"/> Allergens (Animals, Dust, Pollen, Mold, Food) <input type="checkbox"/> Exercise/Increased Activity <input type="checkbox"/> Heat/Humidity <input type="checkbox"/> Cold Air
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Don't know <input type="checkbox"/> 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.

<input type="checkbox"/> The patient is seldom active	<input type="checkbox"/> No limit to any activities or play	<input type="checkbox"/> Performance in sports or play is reduced
<input type="checkbox"/> Sometimes have to <u>stop</u> activities or play due to breathing problems	<input type="checkbox"/> Has to <u>avoid</u> 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?

<input type="checkbox"/> All of the time	<input type="checkbox"/> about 75% of the time	<input type="checkbox"/> About 50% of the time	<input type="checkbox"/> Less than 50% of the time
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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 2 or more times a month 2 or more times 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 more 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
 Spirometry IOS ENO