



# ASTHMA PATIENT QUESTIONNAIRE

## Follow up visit

Patient's Name: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_ Phone number \_\_\_\_\_

1. Does your child have any current asthma problems or do you have any concerns? Yes No
  
2. **SINCE YOUR LAST VISIT**, does your child have frequent episodes of (check all that apply):
  - **COUGHING** Yes No  
Average # of episodes per week \_\_\_\_\_
  - **ONGOING NIGHTTIME COUGH** Yes No  
Average # of episodes per week \_\_\_\_\_
  - **AUDIBLE WHEEZING** Yes No  
Average # of episodes per week \_\_\_\_\_
  - **DIFFICULTY BREATHING/SHORTNESS OF BREATH WITHOUT ACTIVITY** Yes No  
Average # of episodes per week \_\_\_\_\_
  - **DIFFICULTY BREATHING/SHORTNESS OF BREATH WITH ACTIVITY** Yes No  
How many episodes per week \_\_\_\_\_ Which activities? \_\_\_\_\_
  - **PROLONGED OR EXCESSIVE COUGH WITH COLDS** Yes No
  - When is the last time you used Albuterol ( Rescue medicine)? \_\_\_\_\_
  
3. Since your last visit, how many flare-ups (exacerbations or attacks) of your child's symptoms have occurred?  
None \_\_\_\_\_ 1-2 \_\_\_\_\_ 3 or more \_\_\_\_\_
  
4. Since your last visit, how many times has your child required oral (liquid or tablet) steroids to control an asthma flare-up? None \_\_\_\_\_ 1-2 \_\_\_\_\_ 3 or more \_\_\_\_\_
  
5. Since your last visit, has your child been in the emergency room for asthma or breathing problems? Yes No  
If yes, how many times \_\_\_\_\_
  
6. Since your last visit, has your child been diagnosed with pneumonia? Yes No  
If yes, how many times \_\_\_\_\_
  
7. Since your last visit, has your child been hospitalized for asthma, pneumonia, bronchitis, RSV, bronchiolitis, or other breathing problems? Yes No  
If yes, how many times \_\_\_\_\_
  
8. Since your last visit, has your child missed school or other activities because of asthma or breathing problems? Yes No  
If yes, approximated number of days missed \_\_\_\_\_
  
9. Since your last visit, have you missed work to care for your child because of asthma or breathing problems? Yes No
  
10. Do any of the following items trigger your child's asthma symptoms or cause flare-ups :
 

|                              |     |    |          |
|------------------------------|-----|----|----------|
| Household dust               | Yes | No | Not sure |
| Respiratory infections/colds | Yes | No | Not sure |
| Aspirin                      | Yes | No | Not sure |
| Foods                        | Yes | No | Not sure |
| If yes, which foods _____    |     |    |          |
| Exercise                     | Yes | No | Not sure |
| Cold air                     | Yes | No | Not sure |
| Perfumes                     | Yes | No | Not sure |
| Exposure to pets, list pets: | Yes | No | Not sure |

- |  |     |    |          |
|--|-----|----|----------|
| Pollens or certain seasons of year                       | Yes | No | Not sure |
| If yes, which seasons (circle) Fall Winter Spring Summer |     |    |          |
| Emotion  | Yes | No | Not sure |
| Mold   | Yes | No | Not sure |
| Other irritants  | Yes | No | Not sure |
| Smoke (cigarette, fireplace, wood)                       | Yes | No | Not sure |
11. Does anyone in your home use a wood burning fireplace or stove? Yes No
  12. Is your child, child's caregiver, or parent a smoker? Yes No
  13. Is your child exposed to tobacco smoke in your home or any other home she/he visits frequently? Yes No
  14. Is your child exposed to tobacco smoke at daycare/school/work? Yes No
  15. Does anyone use tobacco products in your car? Yes No
  16. Did your child receive a flu shot (influenza vaccine) this season? Yes No
  17. Does the family have a home nebulizer machine? Yes No  
     If yes, do you feel comfortable using it and keeping it clean? Yes No
  18. Do you have a spacer device (aerochamber) to use with your child's inhalers? Yes No  
     If yes, do you feel comfortable using it and keeping it clean? Yes No  
     If yes, do you have an inhaler and spacer for use at school/daycare? Yes No
  19. Does your child have a peak flow meter to measure lung function at home? Yes No  
     If yes, how often are peak flows measured? \_\_\_\_\_  
     What is your child's personal best measure? \_\_\_\_\_
  20. Does your child have a written asthma action plan (AAP)? Yes No  
     If yes, do you understand how to use it to care for your child's asthma? Yes No  
     If not, have you been instructed by the physician on how to use the medications prescribed for their asthma? Yes No
  21. Does your child's school have a copy of your child's Asthma Action Plan? Yes No
  22. Does your child have a spacer and peak flow meter for school/daycare? Yes No
  23. Please list your child's current asthma and allergy medications.

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24. Since your last visit, has your child experienced any side effects from taking his/her asthma medicines?

|   |              |                  |               |
|---|--------------|------------------|---------------|
| <i>(Circle one number in each row):</i> | <b>Never</b> | <b>Sometimes</b> | <b>Always</b> |
| Sleeping difficulty                     | 1            | 2                | 3             |
| Shakiness (tremors)                     | 1            | 2                | 3             |
| Rapid heart rate                        | 1            | 2                | 3             |
| Headaches                               | 1            | 2                | 3             |
| Moodiness/irritability                  | 1            | 2                | 3             |
| Hoarseness                              | 1            | 2                | 3             |
| Thrush/yeast infections                 | 1            | 2                | 3             |