



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
- **USE OF RESCUE (QUICK RELIEF) MEDICATION**
How many time per week do you use your rescue medicine not counting before exercise? _____
When is the last time you used your 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 _____

- TURN OVER-

If you do not understand any of these questions, please ask your nurse.

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 for school/daycare? Yes No
23. Please list your child's current asthma and allergy medications.

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

(Circle one number in each row):

	Never	Sometimes	Always
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

If you do not understand any of these questions, please ask your nurse.