



# ASTHMA PATIENT QUESTIONNAIRE

## Initial visit

Patient Name: \_\_\_\_\_

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

1. Does your child have any current asthma or breathing problems or do you have any concerns? Yes No
2. Has your child ever been told by a medical care provider that he/she has asthma? Yes No
3. Has he/she ever been evaluated by an allergist or pulmonologist (lung specialist)? Yes No
4. Ever had allergy testing? Yes No  
 If yes, name of doctor: \_\_\_\_\_
5. 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
6. How many flare-ups (exacerbations or attacks) of his/her symptoms have occurred in the past 6 months?  
 None \_\_\_\_\_ 1-2 \_\_\_\_\_ 3 or more \_\_\_\_\_
7. How many times in the past 6 months has he/she required oral (liquid or tablet) steroids to control an attack?  
 None \_\_\_\_\_ 1-2 \_\_\_\_\_ 3 or more \_\_\_\_\_
8. Has your child ever been to the emergency room for asthma or breathing problems? Yes No  
 If yes, how many times in the past year \_\_\_\_\_
9. Has your child ever been diagnosed with pneumonia? Yes No  
 If yes, how many times \_\_\_\_\_
10. Has your child ever been hospitalized for asthma, pneumonia, bronchitis, RSV, bronchiolitis, or other breathing problems? Yes No  
 If yes, how many times in the past year \_\_\_\_\_
11. In the past 6 months, has he/she missed school or other activities because of asthma or breathing problems? Yes No  
 If yes, how many times \_\_\_\_\_
12. Missed work (either as a parent or patient) in the past 6 months due to breathing problems? Yes No
13. Do any of the following trigger your child's symptoms?
 

Household dust		Yes	No	Not sure
Respiratory infections/cold		Yes	No	Not sure
Aspirin		Yes	No	Not sure
Foods	If yes, which foods _____	Yes	No	Not sure
Exercise		Yes	No	Not sure
Cold air		Yes	No	Not sure
Perfume		Yes	No	Not sure
Pets at home, work, or daycare?	If yes, 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

14. Does anyone in your home use a wood burning fireplace or stove? Yes No
15. Is your child, child's caregiver, or parent a smoker? Yes No
16. Is your child exposed to tobacco smoke in his/her home or any other home they frequently visit? Yes No
17. Is your child exposed to tobacco smoke at daycare/school/work? Yes No
18. Does anyone use tobacco products in your car? Yes No
19. Has your child ever had any of the following:
- |   |     |    |          |
|---|-----|----|----------|
| Allergies, hay fever, or rhinitis                             | Yes | No | Not sure |
| Hives   | Yes | No | Not sure |
| Eczema  | Yes | No | Not sure |
| Recurrent sinus/ear infections                                | Yes | No | Not sure |
| Nasal polyps  | Yes | No | Not sure |
| Family members who have also had asthma, eczema, or allergies | Yes | No | Not sure |
- If yes, who \_\_\_\_\_

**MEDICATIONS:**

List current medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

20. Does your child experience any of the following side effects from taking your asthma medicines?

*(Circle one number in each row):*

	<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

21. Did your child receive a flu shot (influenza vaccine) this season? Yes No
22. Has your child ever had a pneumovax (pneumonia vaccine)? Yes No
23. Does the family have a home nebulizer machine? Yes No  
    If yes, do you feel comfortable using it and keeping it clean? Yes No
24. Do you have a spacer device (aerochamber) to use with your 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
25. Do you have a peak flow meter to measure lung function at home? Yes No  
    If yes, how often are you monitoring peak flows per week? \_\_\_\_\_  
    What is your child's personal best peak flow? \_\_\_\_\_
26. Does your child have a written Asthma Action Plan? Yes No  
    If **yes**, do you understand how to use it to care for your child's asthma? Yes No  
    If **no**, have you been instructed by the physician on how to use the medications? Yes No
27. Does your child's school have a copy of your child's Asthma Action Plan? Yes No
28. Does your child have a spacer or peak flow meter at school? Yes No