



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

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

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):

	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

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

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

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| 25. Do you have a peak flow meter to measure lung function at home?
If yes, how often are you monitoring peak flows per week? _____
What is your child's personal best peak flow? _____ | Yes No |
| 26. Does your child have a written Asthma Action Plan?
If yes , do you understand how to use it to care for your child's asthma?
If no , have you been instructed by the physician on how to use the medications? | Yes No
Yes No
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 |

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