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
     Average # of episodes per week _______
   - ONGOING NIGHTTIME COUGH
     Average # of episodes per week_______
   - AUDIBLE WHEEZING
     Average # of episodes per week_______
   - DIFFICULTY BREATHING/SHORTNESS OF BREATH
     WITHOUT ACTIVITY
     Average # of episodes per week________
   - DIFFICULTY BREATHING/SHORTNESS OF BREATH
     WITH ACTIVITY
     How many episodes per week_______ Which activities?_______________
   - PROLONGED OR EXCESSIVE COUGH WITH Colds
     How many times per week do you use your rescue medicine not counting before exercise? ____________
     When was 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

---

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

Reproduction is allowed with permission from Complete Children’s Health, P.C.  
(402) 465-5600  
Revised 1/9/2017
10. Circle any of the following items that trigger your child’s asthma symptoms or cause flare-ups:

- Dust
- Respiratory infections/colds
- Emotion
- Smoke
- Mold

Seasonal allergies: (spring summer fall winter)
- Exercise/activity
- Perfume
- Strong smells
- Weather changes
- Cold air
- Other: __________

11. Do you have pets at home? If so list_______________________________________________________

Do you have any food allergies? If so list: __________________________________________________

12. Is your child exposed to smoke at: Home Work Daycare Grandparents Fireplace Other

13. Does anyone use tobacco products in your car? Yes No

14. Did your child receive a flu shot (influenza vaccine) this season? Yes No

15. Do you have a home nebulizer machine? Yes No

16. Do you USE a spacer device/aerochamber to administer your child’s inhalers? Yes No

17. 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? __________

18. Do you feel comfortable using and cleaning your asthma devices? Yes No

19. Does your child have a written asthma action plan (AAP)? Yes No

20. Does your child’s school have a copy of your child’s Asthma Action Plan? Yes No

21. Does your child have a spacer at school/daycare? Yes No

22. How many days a week does your child get their medicine? (out of 7) ______________

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

(Circle one number in each row):

- Sleeping difficulty
  - Never 1
  - Sometimes 2
  - Always 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

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