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 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

Turn Over Please

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

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):	**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

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