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

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

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