

Patient Name _____ Date of Birth _____

Today's Date _____

1. How much of the time did asthma keep you from getting as much done at work, school or home?

IN THE PAST 4 WEEKS:

1 ALL OF THE TIME
 2 MOST OF THE TIME
 3 SOME OF THE TIME
 4 A LITTLE OF THE TIME
 5 NONE OF THE TIME

IN THE PAST 6 MONTHS:

1 ALL OF THE TIME
 2 MOST OF THE TIME
 3 SOME OF THE TIME
 4 A LITTLE OF THE TIME
 5 NONE OF THE TIME

2. How often have you had shortness of breath?

IN THE PAST 4 WEEKS:

1 MORE THAN ONCE A DAY
 2 ONCE A DAY
 3 3-6 TIMES/WEEK
 4 ONCE OR TWICE/WEEK
 5 NOT AT ALL

IN THE PAST 6 MONTHS:

1 MORE THAN ONCE A DAY
 2 ONCE A DAY
 3 3-6 TIMES/WEEK
 4 ONCE OR TWICE/WEEK
 5 NOT AT ALL

3. How often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you at night or earlier than usual in the morning?

IN THE PAST 4 WEEKS:

1 4 OR MORE NIGHTS/WEEK
 2 2-3 NIGHTS/WEEK
 3 ONCE A WEEK
 4 ONCE OR TWICE
 5 NOT AT ALL

IN THE PAST 6 MONTHS:

1 4 OR MORE NIGHTS/WEEK
 2 2-3 NIGHTS/WEEK
 3 ONCE A WEEK
 4 ONCE OR TWICE
 5 NOT AT ALL

4. How often have you used your rescue inhaler or nebulizer medication such as Albuterol?

IN THE PAST 4 WEEKS:

1 3 OR MORE TIMES/DAY
 2 1-2 TIMES/DAY
 3 2-3 TIMES/WEEK
 4 ONCE A WEEK OR LESS
 5 NOT AT ALL

IN THE PAST 6 MONTHS:

1 3 OR MORE TIMES/DAY
 2 1-2 TIMES/DAY
 3 2-3 TIMES/WEEK
 4 ONCE A WEEK OR LESS
 5 NOT AT ALL

5. How would you rate your asthma control?

IN THE PAST 4 WEEKS:

1 NOT CONTROLLED AT ALL
 2 POORLY CONTROLLED
 3 SOMEWHAT CONTROLLED
 4 WELL CONTROLLED
 5 COMPLETELY CONTROLLED

IN THE PAST 6 MONTHS:

1 NOT CONTROLLED AT ALL
 2 POORLY CONTROLLED
 3 SOMEWHAT CONTROLLED
 4 WELL CONTROLLED
 5 COMPLETELY CONTROLLED

TOTAL

GENERAL QUESTIONS:

If your child has seen an allergist, please list name of doctor _____ Last visit _____
Next visit to be scheduled _____

Please list current medications: _____

Do you check peak flows? ___Yes ___No; if yes, what is your personal best peak flow? _____
What was your peak flow over the past few weeks? _____

How many courses of oral steroids have you taken this past year? (Orapred, Prednisone, Prednisolone)

Is there any exposure to cigarette smoke? ___Yes ___No

Do you have any environmental allergies? ___Yes ___No. If yes, to what _____

Please list dates of any ER or Urgent Care visits due to asthma in the last year? _____