Partners in Pediatrics, LLC

Asthma Follow Up Questionnaire

Please help our practice improve the care we provide your child with asthma. Our goal is for your child to be symptom free, sleep well and participate in all activities. Your nurse or doctor will review these questions with you.

Visit Date _____/_____/______ **Severity Score: ________________**

Patient Name ____________________________ Date of Birth ____/____/____ Med Record # ____________

Name of person completing history______________________ Relationship to child ___________________

Type of Visit: ( ) **Well visit** ( ) **Asthma Check** ( ) **Sick today**

SYM--**SYM**

In the past *4 weeks* how frequently has your child:

a) Experienced cough, shortness of breath, wheezing or reduced activity (asthma symptoms) during the DAY?
(5) None (4) < 2 days/week (3) 3 to 6 days/week (2) daily (1) throughout the day

b) Experienced cough, shortness of breath, wheezing or reduced activity (asthma symptoms) at NIGHT?
(5) None (4) < 2 days/month (3) 3 to 4 night/month (2) > once /week (1) most nights

c) Needed a QUICK RELIEF MEDICINE for symptoms? Examples: Albuterol, Xopenex, Proair, Proventil, Ventolin)
(5) not at all (4) once a week or less (3) few times a week (2) more than once any day (1) 3 or more any day

QUA--**QUA**

In the past *4 weeks* has asthma limited your child's ACTIVITIES at home or school?
(5) not at all (4) a little of the time (3) some of the time (2) most of the time (1)) all of the time

In the past *4 weeks* my child's asthma CONTROL is:
(5) Completely controlled (4) well controlled (3) somewhat controlled (2) poorly controlled (1) not at all controlled

SEV--**SEV**

In the past *12 months* was your child:

a) Admitted to a hospital for asthma? ( ) yes ( ) no

b) Treated at an ED or Urgent Care Center for asthma or breathing problems? ( ) yes ( ) no

c) Prescribed an Oral Steroid medicine (Prednisone, Orapred) for Asthma? ( ) yes ( ) no

d) Evaluated by an Allergist or pulmonologist? ( ) yes ( ) no

TIM--**TIM**

How many days of school/daycare has your child missed *due to asthma* in the past *6 months?* _________days

How many work days did an adult missed *due to your child's asthma* in the past *6 months?* _________days

CON--**CON**

Do you have a written Asthma Action Plan? ( ) yes ( ) no

During the past month is your child taking any DAILY control medicines for Asthma or Allergic Rhinitis (Atopy)?
Please List

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Do you have a spacer? ( ) yes ( ) no

MOD--**MOD**

When are Asthma symptoms worse? Check all that apply

( ) winter ( ) spring ( ) summer ( ) fall ( ) during exercise – Used inhaler? ( ) yes ( ) no

Do you notice any triggers that start the cough or seem to make the Asthma worse?

( ) tobacco smoke ( ) animals ( ) change in weather
( ) perfumes ( ) mold or dust ( ) certain places
( ) viral respiratory infections, a cold ( ) allergic rhinitis, "sinus"

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In our effort to improve patient care, please read the following.

Previously we treated your child for asthma symptoms.

During the past 12 months has your child:

1. **Coughed now and then for no good reason?**
2. **Coughed when laughing?**
3. **Coughed with aerobic exercise?**
4. **Taken any medicines using an inhaler (By mouth not nose) or a nebulizer?**

If yes to any of these questions, then please complete the form on the other side.

If no, then return this form to the nurse.

Thank you!

OFFICE USE ONLY
Physician Review

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