

Date: _____ Living with Asthma Patient Name _____

Please complete this survey. Your answer will help us take better care of your child with asthma. If you need help, please ask a staff member. Thank You!

1. My child is here today for:
- A planned visit (for well-child care, asthma follow-up, or a review of how my child is doing)
 - A "sick" visit for an asthma flare-up → If this is a "sick" visit, what triggered the flare-up?

 - Other reason for visit: _____

For questions 2 and 3, check one choice in each question describing your child's health in **the past 2 weeks**:

2. In the past 2 weeks, my child has had **DAYTIME** coughing, wheezing or shortness of breath:

- Every day, all the time
- Every day, but not all the time
- More than 2 times a week, but not every day
- 2 times a week or less
- Never

3. In the past 2 weeks, my child has been bothered by **NIGHTTIME** coughing, wheezing or shortness of breath:

- Frequently / Every night
- More than once a week
- Once a week
- Once every 2 weeks or less
- Never

For Clinician Use Only:

Classify severity:

Before therapy is attained: by symptoms and objective measures;
After optimal therapy: by treatment needed to maintain control.

- Mild Intermittent
- Mild Persistent
- Moderate Persistent
- Severe Persistent

4. **In the past 30 days**, has anyone, including yourself, smoked tobacco anywhere inside your home or a home your child frequently visits?
 No Yes Don't know / Not Sure
5. **In the past 2 months**:
I have (or another caregiver has) missed days of school or work because of my child's asthma:
 No Yes → If "Yes," number of days missed _____ I don't go to school or work
My child has missed school or childcare because of asthma:
 No Yes → If "Yes," number of days missed _____ Child doesn't go to school or childcare
6. **In the past 2 months**, I have done the following at home to reduce my child's symptoms (**check all that apply**):
 I changed smoking habits Special mattress or pillow covers Washed linens in hot water Other: _____
 Increased vacuuming Reduced pet exposure I haven't done anything
7. **In the past 6 months**, my child has visited the following, **due to an asthma flare-up**:
A physician's office or clinic No Yes → If "Yes," number of times: _____
Emergency Room No Yes → If "Yes," number of times: _____
Was hospitalized as an inpatient No Yes → If "Yes," number of times: _____
8. Do you agree that you feel confident about managing your own or your child's asthma?
 Strongly Agree Agree Neutral Disagree Strongly Disagree
9. For each type of asthma medicine, please **CIRCLE THE MEDICINE** and **CHECK** how often it is used by your child.

Asthma Medicine Group	Every Day	3 or more times in the past week	1 or 2 times in the past week	Did not use
Quick relief —albuterol (Proventil, Ventolin), Maxair, Xopenex				
Inhaled steroid —Flovent, Pulmicort, Advair, AeroBid, Azmacort, Beclovent, Vancril				
Singulair, Accolate				
Cromolyn (Intal)				
Long acting "albuterol" - Serevent, Proventil Repetabs, Volmax				
Steroid by mouth --Prednisone, Prelone, Orapred, Pediapred, Decadron				

10. An asthma action plan is a written set of instructions about how to treat your child's asthma, with different treatments depending on how your child's asthma is doing. Do you have an **UP TO DATE** written copy of an asthma action plan for your child?
 No → If "No," you are done with the survey Not Sure → If "Not Sure," you are done with the survey.
 Yes → If "Yes," who has a copy of the plan? (**check all that apply**):
 I have a plan at home
 My child's childcare or school has a copy of the plan

Please return the survey to the office staff. Thank you very much for completing this survey!

Clinician Signature: _____ Date: _____

Source: Fight Asthma Milwaukee Allies, Adapted with permission from National Initiative for Children's Healthcare Quality, 3/03