Initial Asthma Questionnaire

Date of Class: ____________  Child’s Name: ______________________________________________

Child’s Date of Birth: ______________________   Child’s Age: ____________________________

1. How would you classify your level of understanding regarding your child’s asthma or breathing problems?
   - Very Knowledgeable
   - Somewhat knowledgeable
   - Lacking knowledge on the topic

   Comments:
   __________________________________________________________________________________________
   __________________________________________________________________________________________

2. How would you classify your level of understanding regarding the treatment of your child’s asthma or breathing problems?
   - Very Knowledgeable
   - Somewhat knowledgeable
   - Lacking knowledge on the topic

   Comments:
   __________________________________________________________________________________________
   __________________________________________________________________________________________

3. Please select the most appropriate answer to the following questions. If these symptoms are worse only part of the year, answer the questions for that part of the year.

<table>
<thead>
<tr>
<th></th>
<th>I*</th>
<th>II*</th>
<th>III*</th>
<th>IV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often are breathing problems, coughing or wheezing occurring during the DAY?</td>
<td></td>
<td>Less than once a week</td>
<td>More than once a week</td>
<td>Daily symptoms</td>
</tr>
<tr>
<td>How often are breathing problems, coughing or wheezing occurring during the NIGHT?</td>
<td></td>
<td>Less than twice a month</td>
<td>More than twice a month</td>
<td>More than once a week</td>
</tr>
<tr>
<td>Does physical activity cause breathing problems, coughing or wheezing?</td>
<td></td>
<td>No, or rarely</td>
<td>Sometimes</td>
<td>Usually</td>
</tr>
<tr>
<td>How often is an inhaler or nebulizer used to treat these problems?</td>
<td></td>
<td>Rarely or only with exercise</td>
<td>4 or more times a month</td>
<td>Daily use</td>
</tr>
</tbody>
</table>

Comments:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

(additional questions on reverse side)
Initial Asthma Questionnaire
cont’d.

4. Has your child missed any regular activities, such as participating in sporting activities or playing outside, due to his/her asthma or breathing problems?
   □ Yes     □ No

   If yes, by what percentage would you estimate your child has reduced his or her regular activities?
   □ 10%     □ 25%     □ 50%     □ 75%     □ 100%

Comments:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

5. If your child attends school or daycare, during the past 6 months, how many days of school or daycare have been missed due to your child’s asthma or breathing problems? ________________

Comments:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

6. During the past 6 months, how many days of work for the parent/guardian have been missed due to the child’s asthma or breathing problems? ________________

Comments:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

7. Due to your child’s asthma or breathing problems, in the past year, have you had any:
   □ Unplanned trips to your child’s pediatrician (including our Evening Hours Office)
     How many? ________________
   □ Trips to an emergency room, urgent care facility or walk-in clinic
     How many? ________________
   □ Unscheduled hospitalizations
     How many? ________________

Comments:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

*For Office Use
Classification of symptoms:
I = Mild Intermittent  II= Mild Persistent  III= Moderate Persistent  IV. = Severe Persistent

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