

## ASTHMA QUESTIONNAIRE

Name \_\_\_\_\_

Date of Service \_\_\_\_\_

### Since your last visit to our office:

1. How often have you/your child used your rescue medicine (eg albuterol, Xopenex, Maxair) for coughing, wheezing, chest tightness or shortness of breath?

Never  Rarely  doses/month  doses/week  doses/day

2. Do you/your child use your bronchodilator inhaler 10-15 minutes before exercise?

No  Yes  doses/ month  doses/week  doses/day

3. Do you/your child have difficulty with exercise even when you use the inhaler ahead of time?

No  Yes **If yes, what type of exercise?**

4. How often does coughing, wheezing, chest tightness or shortness of breath awaken you/your child at night?

Never  Rarely  times/month  times/week  times/night  seasonally **Sp/S/F/W (circle one)**

5. How often do your asthma symptoms cause you/your child to miss work or school?

Never  Rarely  times/month  times/week  seasonally **Sp/S/F/W (circle one)**

6. Have you/your child been in the emergency room or urgent care?

No  Yes  number of visits since your last office visit

7. Have you/your child needed oral steroid medicines (prednisone, Orapred, Prelone, Pediapred, Medrol)?

No  Yes  number of courses since your last office visit

8. How often have you/your child missed a dose of your maintenance/preventative medications? (Advair, Flovent, Pulmicort, Asmanex, Singulair)

Never  Rarely  times/month  times/week  times/day

9. How often have you/your child had the following symptoms?

	NEVER	RARELY	SEVERAL TIMES/MO	SEVERAL TIME/WK	SEVERAL TIMES/DAY	WHICH SEASONS? SP/S/F/W
Nasal & eye symptoms						
Runny Nose						
Stuffy nose/congestion						
Itchy nose						
Sneezing						
Sniffing						
Post nasal drainage						
Sinus headaches						
Itchy/red/watery eyes						

10. Have you/your child needed antibiotics since your last office visit?

No  Yes **If yes, which antibiotic for what type of infection?**

**How many times have you/your child needed antibiotics since last seen here?**