Asthma Assessment Form

Please complete the following form regarding your child's asthma. This will help us better understand and effectively treat your child's asthma.

1. Ethnic Background:
   - American Indian
   - Asian/Hawaiian/Pacific Islands
   - Black/African American
   - Caucasian
   - Hispanic
   - Other: ________________________________

2. What concerns you the most about your child's asthma?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

3. How does asthma affect family routine and activities?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

4. Please list all medications at home that your child is currently taking (Include creams, inhalers, nasal sprays):

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

5. Please list all medications at home that your child is not currently taking (Include creams, inhalers, nasal sprays):

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

6. Which type of device(s) is currently used to administer your child's medications? (Select all that apply)
   - Nebulizer:       □ with a facemask □ with the mouthpiece □ child cooperative? □ Yes □ No
   - Spacer:         □ with a facemask □ without a facemask □ child cooperative? □ Yes □ No
   - Inhaler alone, we do not use a spacer or valved holding chamber.
7. Does your child have a spacer for home use and one for school/daycare? □ Yes □ No

8. Do you need another spacer/valved holding chamber today? □ Yes □ No

9. Do you have an updated asthma action plan? □ Yes □ No

10. How many times in the last 12 months has your child:
   - Received oral steroids for difficulty breathing, coughing, chest tightness and wheezing
     □ (1 – 2 times) □ (3 – 4 times) □ (5 or more times)
   - Gone to the doctor for a walk-in/urgent care visit for asthma
     □ (1 – 2 times) □ (3 – 4 times) □ (5 or more times)
   - Gone to the emergency room at the hospital for asthma
     □ (1 time) □ (2 times) □ (3 or more times)
   - Stayed overnight at the hospital?
     □ (1 time) □ (2 times) □ (3 or more times)
   - Missed school due to asthma symptoms?
     □ (1-5) days □ (6-10 days) □ (11 or more days)

11. Has your child ever been diagnosed with asthma by any doctor they have seen in the past? □ Yes □ No
   If Yes, at what age? ____________________________________________

12. Check all the symptoms you have noticed since your child started having trouble breathing.
   □ Cough
   □ Wheeze
   □ Difficulty breathing while being still
   □ Difficulty breathing with exercise/running: coughing, tightness of chest, easily out of breath
   □ Difficulty breathing at night: cough, chest tightness or wheezing during the night
   If so, when did these symptoms start?
   ____________________________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

13. What is the child’s level of smoke exposure? (Select all that apply)
   □ None
   □ Family/caregivers smoke inside home
   □ Family/caregivers smoke in vehicle
   □ Family/caregivers smoke outside only

14. During which time of the year does your child have the most difficulty breathing, coughing, wheezing, chest tightness?
   □ Fall
   □ Winter
   □ Spring
   □ Summer
   □ All Year Round
15. During which time of the day does your child have the most difficulty breathing, coughing, wheezing, chest tightness?
- Morning
- Afternoon
- Evening
- During the night while sleeping

16. Select **ALL** the triggers that cause your child to have difficulty breathing, coughing, wheezing, chest tightness?
- Respiratory Infections
- Sinus Infection
- Casual Activity
- Vigorous Activity
- Emotional Excitement (crying, laughing, anger)
- Exercise
- Strong Smells or Perfumes
- Tobacco Smoke
- Weather Changes
- Cold Air
- I don’t know

☐ Allergens
Please list all known allergens: ________________________________________________________________
_____________________________________________________________________________________

☐ Animals
If yes, which ones________________________________________________________

☐ Foods
If yes, which ones___________________________________________________

☐ Specific locations (such as school, daycare)_______________________________________________

17. Does your child have a history of **eczema**?  ☐ Yes ☐ No

18. Was your child ever hospitalized for Respiratory syncytial virus (RSV)?  ☐ Yes ☐ No

19. Does your child have a history of the following? (Select all that apply)
- Sinus problems
- Nasal congestion
- Headaches
- Post nasal drip

20. Does your child have a history of the following? (Select all that apply)
- Reflux or burping
- Frequent stomach aches
- Chest pain

21. Which best describes where the child lives.
- Apartment
- House
- Mobile home/Trailer
22. How do you **cool** your home?  
- Air conditioning  
- Fan  
- Open windows  

How do you **heat** your home?  
- Heat pump  
- Wood stove  
- Oven  
- Space heater  
- Electric heat

23. What type of flooring is in the home? (Select all that apply)  
- Throw rugs  
- Carpet  
- Vinyl  
- Tile  
- Wood

What type of flooring is in the child’s room? (Select all that apply)  
- Throw rugs  
- Carpet  
- Vinyl  
- Tile  
- Wood

24. Does anyone in the family have a history of asthma or allergies?  
- Mother  
- Father  
- Brother  
- Sister  
- Grandmother – mom’s side  
- Grandfather – mom’s side  
- Grandmother – dad’s side  
- Grandfather – dad’s side  
- Other:______________________________

Thank you for completing this questionnaire.

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**For Provider/Staff Use:**

Is Asthma Severity Classification noted in the chart for this visit?  
- No  
- Yes  

If No, classify now.

If Yes, what is the classification of severity?  
- Mild Intermittent  
- Mild Persistent  
- Moderate Persistent  
- Severe Persistent