Child's Name:____

Child's Date of Birth:____

Child's Age:____

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 **<u>IS</u>** currently taking (Include creams, inhalers, nasal sprays):
   ____
   ____
   ____
   ____
   ____
   ____

5. Please all medications at home that your child **<u>IS NOT</u>** 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 Is child cooperative? ☐ Yes ☐ No
   ☐ Spacer: ☐ with a facemask ☐ without a facemask Is 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 If Yes, at what age?___________________________
    ☐ No

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 the 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 the 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.

For Provider/Staff Use:

Is Asthma Severity Classification noted in the chart for this visit?

☐ No If No, classify now.

☐ Yes If Yes, what is the classification of severity?

☐ Mild Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent