

# Asthma Data Collection Form – 2015



Patient Name: \_\_\_\_\_, Date of Birth: \_\_\_/\_\_\_/\_\_\_, Physician Name: \_\_\_\_\_

Patient E-mail: \_\_\_\_\_, Date of Visit: \_\_\_/\_\_\_/\_\_\_

asthma well visit     asthma sick visit     asthma sick visit follow up     phone visit     other visit

## PARENT SECTION - Please Complete Questions 1-15. Thank you for helping us care for your child

1. How many days of school/daycare has your child missed **due to asthma** in the **past 6 months**? \_\_\_ # of days     Does not attend
2. How many work days have you or your spouse missed **due to your child's asthma** in the **past 6 months**? \_\_\_ # of days     Does not apply
3. Has your child visited the Emergency Room or Urgent Care Center **due to asthma** in the **past 12 months**?     YES     NO
4. Has your child been admitted to the hospital **due to asthma** in the **past 12 months**?     YES     NO
- 5a. How comfortable are you taking care of your child with asthma when he/she is sick or well?  
Not Comfortable = 1    2    3    4    5    6    7    8    9    10 = Very Comfortable
- 5b. What would make you feel more comfortable/confident? \_\_\_\_\_
6. During the **past 4 weeks**, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or reduced activity **due to asthma during the DAY**?     ≤ 2 days / week     > 2 days / week but not daily     Daily     Throughout the day
7. During the **past 4 weeks**, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or waking up **due to asthma at NIGHT**?     ≤ 2 times / month     3-4 times a month     > 1 time / week but not nightly     Often 7 times / week
8. During the **past week**, how often did your child need a fast acting or quick relief medication (Rescue Inhaler) at times **other than before exercise**? (includes Albuterol, Ventolin®, Proventil®, Xopenex®)  
 Not sure     Not at all     Less than 1 time per day     1-3 times per day     4 or more times per day
9. Does your child use a spacer with his/her inhaler?     YES     NO     Not sure
10. When are **asthma** symptoms worse? (**Check all that apply**)     Winter     Spring     Summer     Fall     All     None
11. Please mark **all** things that make your child's **asthma** worse:  
 Respiratory Infections     Irritants (Tobacco Smoke, Wood Smoke, Air Pollution, Perfumes, Incense, Other Irritant)  
 Changes in Weather     Allergens (Animals, Dust, Pollen, Mold, Food)     Exercise/Increased Activity     Heat/Humidity     Cold Air  
 Other: \_\_\_\_\_     Don't know     None
12. How often does asthma limit your child's activities?  
 Not at all     A little of the time     Some of the time     Most of the time     All of the time
13. How would you rate your child's asthma control during the **past month**?     \*Well controlled     Not well controlled     Very poorly controlled
14. Are you planning to have your child receive the flu vaccine this flu season?     YES     NO-reason: \_\_\_\_\_
15. Are there things **about your child's asthma** you want to discuss with your physician today?

## PHYSICIAN SECTION – Please Complete Questions 16-23

16. Was a recommendation made for the patient to receive the flu vaccine?     YES     NO
17. Asthma severity level:     Intermittent     Mild Persistent     Moderate Persistent     Severe Persistent
- 18a. Is the patient on a controller medication?     YES     →     Seasonal use     Continuous use  
 Started this visit     →     Seasonal use     Continuous use  
 NO
- 18b. If YES, does the patient/parent report using controller medications daily (applies to seasonal and continuous use)?     YES     NO
19. Has the patient received oral steroids for bronchospasm within the **past 12 months**?     YES     NO
- 20a. Does the patient have a written asthma action plan?     YES     NO
- 20b. If YES, was the plan updated as needed and reviewed with the patient and/or family at this visit?     YES     NO
21. Has the patient been seen by an allergist or pulmonologist during the **last 12 months** for assistance with asthma management due to severity of illness?     YES     NO     Referred this visit    Specialist: \_\_\_\_\_
22. How would you rate the patient's asthma control during the **past month**?     \*Well controlled     Not well controlled     Very poorly controlled
23. Has the patient had spirometry within the past 1 – 2 years?     YES: date \_\_\_/\_\_\_/\_\_\_     NO     N/A due to age  
(Per Guidelines for the Diagnosis and Management of Asthma; National Heart, Lung, and Blood Institute; 2007)

Follow-up visit: Return in: \_\_\_ weeks, or \_\_\_ months (Return visit date: \_\_\_ / \_\_\_ / \_\_\_)

\*Well controlled asthma is defined as ♦ symptoms ≤ 2 days/week, ♦ nighttime awakenings ≤ 1 time/month, ♦ no interference with normal activity, ♦ short acting beta<sub>2</sub> agonist use for symptom control ≤ 2 days/week (not prevention of exercise-induced bronchospasm), ♦ exacerbations requiring oral systemic corticosteroids 0-1/year ♦ FEV<sub>1</sub> or peak flow > 80% predicted value or personal best.

(Guidelines for the Diagnosis and Management of Asthma; National Heart, Lung, and Blood Institute; 2007)