Asthma Questionnaire

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Child's Name_____ ID _____ DOB_____ Grade/School Year_____

Parent/Guardian_____Home Phone Number_____

Work Number_____Cell Phone/Pager Number_____

Where does your child receive his/her asthma care: (name of clinic)_____

Name of Physician or Health Care Provider_____Clinic Phone Number_____

1. Please circle if your child's asthma is severe or not severe or anywhere in between (circle #) 1 2 3 4 5
   Not severe Severe

2. How many days did your child miss school **last year** due to his/her asthma?
   □ 0 days □ 1-2 days □ 3-5 days □ 6-9 days □ 10-14 days □ 15 or more days

3. How many times has your child been hospitalized overnight or longer for asthma in the **past 12 months?**
   □ 0 times □ 1 time □ 2 times □ 3 times □ 4 times □ 5 or more times

4. How many times has your child been treated in the Emergency Department for asthma in the **past 12 months?**
   □ 0 times □ 1 time □ 2 times □ 3 times □ 4 times □ 5 or more times

5. What triggers your child's asthma or makes it worse?
   - □ Smoke
   - □ Animals / pets
   - □ Dust / dust mites
   - □ Cockroaches
   - □ Grass / flowers
   - □ Mold
   - □ Exercise, sports or playing hard
   - □ Chalk / chalk dust
   - □ Strong smells / perfume
   - □ Foods (which ones? _____)
   - □ Having a cold / respiratory illness
   - □ Stress or emotional upsets
   - □ Changes in weather / very cold or hot air
   - □ Other (Explain_____)

6. Is your child exposed to smoking? □ Yes □ No If yes, where? _____

7. For each season of the year, to what extent does your child usually have asthma symptoms? (Mark an X for each season below)

	A lot	A little	None
Fall	□	□	□
Winter	□	□	□
Spring	□	□	□
Summer	□	□	□

8. In the past month, <u>during the day,</u> how often has your child had a hard time with coughing, wheezing, breathing?
   □ Less than 2 times a week □ More than 2 times a week
   □ Every day (at least once every day) □ Constantly (all of the time every day)

9. In the past month, <u>during the night,</u> how often does your child wake up or have a hard time with coughing, wheezing or breathing?
   □ 2 times a month or less □ More than 2 times a month □ More than 2 times a week □ Every night

10. Does your child have a written Asthma Action Plan? □ Yes □ No □ Don't know

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11. Does your child use a peak flow meter at home? □ Yes □ No □ Don't know

12. Do you know what your child's personal best peak flow number is? □ Yes → what is it? _____ □ No

13. What are your child's usual signs / symptoms during an asthma attack?
□ wheezing □ coughing □ difficulty breathing □ chest tightness □ anxiety
□ other_____

14. Please list the medications your child takes for asthma or allergies (everyday and as needed)

Medications Taken At Home

Medication Name?	How Much?	When is it Taken?

Medication Orders For School

Medication Name?	How Much?	When should it be taken?

15. What does your child do at home to relieve symptoms during an asthma attack?
□ rests □ drinks fluids □ uses breathing exercises
□ checks peak flow □ takes medication □ other_____

16. How well does your child take his/her asthma medications?
□ Can take medicine by self □ Forgets to take medicine □ Needs help taking medicine □ Not using medicine now

17. Does your child usually use a spacer or holding chamber with his/her metered dose inhaler (a clear tube that attaches to the inhaler and better helps the inhaled medicine get into the lungs)?
□ Yes □ No □ Don't know □ He/she uses a dry powdered inhaler so he/she doesn't need a spacer

18. During the past year has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?
□ Yes □ No □ Don't know

19. Comments_____

_____

_____

Parent
Signature_____Date_____