Jefferson Pediatrics

Pt. Name:_____ Completed By:_____

Date:_____

Age:_____

Asthma Questionnaire:

1. How is your asthma since last visit- good/so so/bad.
2. Which inhalers are you using now and how often name of 1st_____ x/day_____
   2nd_____ x/day_____
3. Do you use inhalers in school? _____yes/no
4. Cough- none/at nights/early morning/during PE/during sports.
5. When was last asthma attack?_____
6. Any Asthma symptoms – tightness/can't breath/cough/dizziness/chest pain/can't play.
7. Severity of the last asthma attack- mild/moderate/severity.
8. When do they usually come on, what brings it on?_____
9. What does the Asthma keeps you from doing?_____
10. What helps relieve Asthma attack- inhalers/rest/stop playing/fresh air.
11. Any pneumonias, hospital visits, or visits to school nurse?
12. How is Asthma affecting your play/school/homework/life?_____
13. Are you exposed to – smoke/perfume/dust/or any other allergens that trigger your Asthma?
14. How do you feel overall?_____
15. Any other concerns you want to discuss?_____