



Patient Name: \_\_\_\_\_

Asthma Data Collection Form

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Date of Visit: \_\_\_/\_\_\_/\_\_\_

(Provider Name)

Insurance Company: \_\_\_\_\_

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

PARENT SECTION - Please Complete Questions 1-12 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?
2. How many work days have you or your spouse missed due to your child's asthma in the past 6 months?
3. Has your child visited the Emergency Room or Urgent Care Center due to asthma in the past 12 months?
4. Has your child been admitted to the hospital due to asthma in the past 12 months?
5. How comfortable are you in your ability to manage your child's asthma, rated on a scale of 1-10?
6. During the past month, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or reduced activity due to asthma during the DAY?
7. During the past month, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or waking up due to asthma at NIGHT?
8. During the past week, how often did your child use a fast acting or quick relief medication, at times other than before exercise?
9. When are asthma symptoms worse?
10. How often does asthma limit your child's activities?
11. How would you rate your child's asthma control during the past month?
12. Are you planning to get a flu shot for your child?

PHYSICIAN SECTION - Please Complete Questions 13-19 Asthma diagnosis tentative

- 13. Asthma severity level: Severe Persistent Moderate Persistent Mild Persistent Mild Intermittent
14. Is the patient on a controller medication? If YES, does the patient/parent report using controller medications daily?
15. For patients who use rescue/controller inhalers, is a spacer utilized?
16. Has the patient received oral steroids for bronchospasm within the past 12 months?
17. Does the family have a copy of a written asthma management plan from a primary care physician or specialist?
18. 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?
19. How would you rate the patient's asthma control during the past month?
20. Has the patient had spirometry within the past 12 months?

\*Complete or total control of asthma is defined as no asthma symptoms; no rescue bronchodilator use; no nighttime or early morning awakening; no limitations on exercise, work or school; complete control of asthma by patient and physician assessment; and normal or personal best PEF or FEV1.

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

(Revised 6/06)