



Adult Asthma Care Management Program

ASTHMA QUESTIONNAIRE

IMPRINT AREA

NAME, ADDRESS, CITY, ZIP, PRIMARY CARE MD/NP, PHONE, BEST TIMES TO CALL, FIRST LANGUAGE, AGE, HT, WT, OCCUPATION, ETHNICITY

AT HOME DO YOU HAVE
Peak flow meter, Asthma Self-Management Plan, Asthma Diary, Spacer device

- How often do you check your peak flows? What is your "Personal Best" Peak Flow?
Have you ever attended our asthma class? Yes No (year)

ASTHMA HISTORY

When were you first diagnosed with asthma? (month/year)
Have you ever: Been hospitalized overnight for asthma? Been to the Emergency room for asthma? Taken a Prednisone "burst" for asthma? Been to urgent care for asthma? How many times in the past 12 months?

USUAL ASTHMA SYMPTOMS

Check the symptoms that you usually experience during an asthma flare: Cough, Chest tightness, Wheezing, Shortness of Breath, Other
How long have you been experiencing these symptoms?
Do you have symptoms only at the same season of the year? Yes No
If yes, what season? Spring, Summer, Fall, Winter

OTHER SYMPTOMS

Do you have mucous in your chest when you cough? Never or rarely, Occasionally or with colds, Almost daily
If you cough up mucous is it: Usually clear, Discolored only with colds, Frequently or always discolored, Sometimes mixed with blood
Do you experience frequent heartburn/indigestion/reflux? Yes No

ASTHMA SEVERITY: WHEN YOU ARE NOT TAKING ASTHMA MEDICATIONS

1. Do you have Daytime Asthma Symptoms: 2 times or less a week, More than 2 times a week but not daily, Daily, Continually, Not sure
2. Do you have Nighttime Asthma Symptoms: 2 times or less a month, More than 2 times per month but less than 2 times a week, More than 1 time per week, Frequently, Not sure
3. How Long Do Your Asthma Flares Last? Flares last a few hours to a few days, Flares affect activity and sleep, Flares occur 2 or more times a week and may last days, Frequent flares, Not sure
4. Peak Flow Readings: Usually in the Green, Usually in the Green Zone, readings vary from day to day, Usually in the Yellow Zone, Usually in low Yellow or Red Zone, Not sure

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

- High blood pressure
 - Emphysema/chronic bronchitis (COPD)
 - Eczema (allergic skin rash)
 - Angina or heart attack
 - Ulcers/acid reflux
 - Sleep apnea
 - Congestive heart failure
 - Hay fever
 - Anxiety or panic attacks
 - Pneumonia
 - Sinusitis or frequent nasal problems
 - Other: _____
 - Tuberculosis (TB) or exposure to TB
 - Nasal polyps
- When was your last flu shot? (year) _____ When was your last TB skin test done? (year) _____
 • When was your last pneumonia vaccine? (year) _____ Do other members of your family have asthma? Yes No

SMOKING HISTORY (CHECK ALL THAT APPLY)

- Never smoked
 - Previously smoked
 - Currently smoking
 - Live with smoker
- If you smoked previously, when did you quit? _____ How many years did you smoke? _____
 What did/do you smoke and how much? Cigarettes _____ packs a day Cigars _____ a day Pipe _____ bowls a day
 If you smoke, are you interested in quitting in the next 6 months? Yes No
 Have you attempted to quit in the past? Yes No If 'yes' what have you tried? _____

CARE BY SPECIALISTS

- Have you ever seen an allergy doctor? Yes No If yes, _____, M.D.
- Have you had allergy testing done in the past? Yes No Are you getting allergy shots? Yes No
- Have you ever seen a Pulmonologist? (lung doctor) Yes No If yes, _____, M.D.
- Have you ever had a Pulmonary Function Test? Yes No If yes, when and where? _____

HOW WELL IS YOUR ASTHMA CURRENTLY CONTROLLED?

In the last 2 weeks, have you:

- Yes No Had problems with asthma symptoms during the day?
 - Yes No Awakened at night due to asthma symptoms?
 - Yes No Had symptoms while exercising?
 - Yes No Had to use your reliever medication more than 2 times per week?
 - Yes No Missed work or school due to your asthma?
 - Yes No Needed to reduce your activities due to asthma?
 - Yes No Have you had any hospitalizations or emergency/urgent visits for asthma?
- What has your peak flow range been in the last 2 weeks? _____ Unknown

PLEASE LIST YOUR ASTHMA MEDICATIONS	PRESCRIBED DOSE	HOW OFTEN DO YOU TAKE THEM?

Are you allergic to any medications? (list) _____

YOUR ENVIRONMENT

- Have any of the following ever triggered your asthma symptoms? Dust Pollens (grass, weeds, trees) Molds
 - Pets Smoke Cold air Humidity Weather change Exercise Emotion/stress Colds/flu
 - Wine or beer Drugs containing aspirin or ibuprofen Strong odors (such as perfumes, soaps, paint, cleaning agents)
 - Foods (list): _____ Other triggers: _____
- Does your job cause or worsen your asthma? Yes No
 • Do you have pets at home? Yes No If yes, which ones? _____
 • Do you use a wood stove or fireplace? Yes No Number of years lived in present home? _____

WHAT QUESTIONS OR CONCERNS DO YOU HAVE ABOUT YOUR ASTHMA?