

## ASTHMA DATA COLLECTION FORM - 2010

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|------------------------------------|-----------------------------------|-----------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Herman    | <input type="checkbox"/> DePiere  | <input type="checkbox"/> Saluke   | <input type="checkbox"/> Vennemeyer | <input type="checkbox"/> Hackenberg-Bauer | <input type="checkbox"/> Gordley         |
| <input type="checkbox"/> Broderick | <input type="checkbox"/> McGovern | <input type="checkbox"/> Schrader | <input type="checkbox"/> Bever      | <input type="checkbox"/> Brady            | <input type="checkbox"/> Lawrence-Hylton |

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Date of Visit: \_\_\_/\_\_\_/\_\_\_  
Patient E-mail: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

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

**PARENT SECTION - Please Complete Questions 1-20. 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

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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

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3. Has your child visited the Emergency Room or Urgent Care Center **due to asthma** in the **past 12 months**?     YES     NO

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4. Has your child been admitted to the hospital **due to asthma** in the **past 12 months**?     YES     NO

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5. 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

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- 5b. what would make you feel more comfortable / confident? \_\_\_\_\_

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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

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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 days / month     3 – 4 times a month     > 1 time / week but not nightly     Often 7 times / week

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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

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9. Does your child use a spacer with his / her inhaler?     YES     NO     Not sure

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10. When are **asthma** symptoms worse? (**Check all that apply**)     Winter     Spring     Summer     Fall     All     None

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11. Please mark all things that make your child's **asthma** worse?  
 Respiratory Infections     Irritants (Tobacco Smoke, Wood Smoke, Air Pollution, Perfumes, Incense, Other Irritants)     Changes in Weather  
 Allergens (Animals, Dust, Pollen, Mold, Food)     Exercise / Increased Activity     Heat / Humidity     Cold Air  
 Other: \_\_\_\_\_     don't know     none

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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

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13. How would you rate your child's asthma control during the **past month**?     Well Controlled     Not well controlled     Very poorly controlled

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14. Are you planning to have your child receive the flu vaccine this flu season?     YES     NO-Reason: \_\_\_\_\_

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15. Are there things **about your child's asthma** you want to discuss with your physician today?

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16. Does the patient have a written asthma action plan?     YES     NO  
If YES, was the plan updated as needed and reviewed with the patient and/or family at this visit?     YES     NO

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- 17a. Is the patient on a controller medication?     YES     Seasonal use     Continuous use  
 started this visit     Seasonal use     Continuous use     NO

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- 17b. If YES, does the patient/parent report using controller medications daily (applies to seasonal and continuous use)?     YES     NO

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18. Has the patient received oral steroids for bronchospasm within the **past 12 months**?     YES     NO

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19. 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: \_\_\_\_\_

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20. Has the patient had spirometry within the past 1 – 2 years?     YES: date \_\_\_/\_\_\_/\_\_\_     NO     N/A due to age

**PHYSICIAN SECTION - PHYSICIAN SECTION \*\*\*\*\* PATIENT/PARENTS - DO NOT FILL BELOW THIS LINE \*\*\*\*\***

21. Was a recommendation made for the patient to receive the flu vaccine?     YES     NO

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22. Asthma severity level:     Intermittent     Mild Persistent     Moderate Persistent     Severe Persistent

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23. How would you rate the patient's asthma control during the past month?     Well Controlled     Not well controlled     Very poorly controlled