

ASTHMA DATA COLLECTION FORM - 2011

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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: ___/___/___

Parent or 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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: _____

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
22. Asthma severity level: Intermittent Mild Persistent Moderate Persistent Severe Persistent
23. How would you rate the patient's asthma control during the past month? Well Controlled Not well controlled Very poorly controlled