

# Pediatric/Adolescent Asthma Therapy Assessment Questionnaire

## IN-OFFICE VERSION

Instructions: Please have the parent or guardian complete this questionnaire.

Patient Name: \_\_\_\_\_ ID number \_\_\_\_\_ Today's Date: \_\_\_\_\_

1. In the **past 4 weeks**, did your child...
- |   | Yes<br>▼                 | No<br>▼                  | Unsure<br>▼              |
|---|--------------------------|--------------------------|--------------------------|
| a) Have wheezing or difficulty breathing when exercising?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have wheezing during the day when <b>not</b> exercising?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Wake up at night with wheezing or difficulty breathing?.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Miss days of school because of his/her asthma? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Miss any daily activities (such as playing, going to a friend's house,.....<br>or any family activity) because of asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Does your child use an inhaler or nebulizer for **quick relief** from asthma symptoms?

Yes.....  →  
No.....   
Unsure.....

(If yes) In the **past 4 weeks**, what was the greatest number of times in one day your child used this inhaler/nebulizer?

0.....   
1 to 2.....   
3 to 4.....   
5 to 6.....   
Over 6.....

(If yes) In the **past 12 months**, on days your child used an inhaler/nebulizer for **quick relief**, how many times a day did he or she **usually** use it?

1 to 2.....   
3 to 4.....   
5 to 6.....   
Over 6.....

3. Has your child ever had a prescription for an asthma medicine that is **NOT** used for quick relief, but is used to **control** your child's asthma?

Yes.....  →  
No.....   
Unsure.....

(If yes) What best describes how your child takes this medicine now?

Takes it every day.....   
Takes it some days, but not other days.....   
Used to take it, but now does not.....   
Only takes it when having symptoms.....   
Never took it.....

4. Are you dissatisfied with any part of your child's **current** asthma treatment?

Yes  
▼  
.....  
No  
▼  
.....  
Unsure  
▼

(If Yes or Unsure) What part of your child's current asthma treatment makes you dissatisfied?

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5. Do you believe...

	Yes ▼	No ▼	Unsure ▼
a) Your child's asthma was well controlled in the <b>past 4 weeks</b> ?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Your child is able to take his/her asthma medicine(s) as directed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) The medicine(s) your child takes are useful for controlling asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. During this office visit, would you like the doctor to...

	Yes ▼	No ▼	Unsure ▼
a) Discuss different types of drugs available to control asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Discuss with you and your child asthma treatment options?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Discuss how your child prefers to take his/her asthma medicine(s)?..... (such as by inhaler, tablet, liquid or nebulizer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>