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 ▼ No ▼ Unsure ▼
   a) Have wheezing or difficulty breathing when exercising? .......................................................... □ □ □
   b) Have wheezing during the day when not exercising? .......................................................... □ □ □
   c) Wake up at night with wheezing or difficulty breathing? .................................................. □ □ □
   d) Miss days of school because of his/her asthma? ................................................................. □ □ □
   e) Miss any daily activities (such as playing, going to a friend’s house, or any family activity) because of asthma?

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?

5. Do you believe...
   Yes ▼ No ▼ Unsure ▼
   a) Your child’s asthma was well controlled in the past 4 weeks? .................................................. □ □ □
   b) Your child is able to take his/her asthma medicine(s) as directed? ............................................. □ □ □
   c) The medicine(s) your child takes are useful for controlling asthma? ........................................... □ □ □

6. During this office visit, would you like the doctor to...
   Yes ▼ No ▼ Unsure ▼
   a) Discuss different types of drugs available to control asthma? ..................................................... □ □ □
   b) Discuss with you and your child asthma treatment options? ...................................................... □ □ □
   c) Discuss how your child prefers to take his/her asthma medicine(s)? ........................................... □ □ □
   (such as by inhaler, tablet, liquid or nebulizer)

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