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 <u>past 4 weeks</u>, 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 <u>quick relief</u> from asthma symptoms?

Yes ☐ →
No ☐
Unsure ☐

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

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

(If yes) In the <u>past 12 months</u>, on days your child used an inhaler/nebulizer for *quick relief*, how many times a day did he or she <u>usually</u> 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 <u>NOT</u> used for quick relief, but is used to <u>control</u> 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 <u>current</u> 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 <u>past 4 weeks</u>?	☐	☐	☐
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)	☐	☐	☐