ASTHMA QUESTIONNAIRE

PATIENT NAME _____ DATE_____

1. Do you use an Asthma Action Plan? ☐**YES** ☐**NO**
2. Your typical asthma symptoms: check all that apply:
   Cough_____ Wheezing_____ Shortness of breath_____ Chest tightness_____
3. In the *past 4 weeks,* did you:
   a) Miss any work, school, or other activities because of your asthma? ☐**YES** ☐**NO**
   b) Wake up at night because of asthma? ☐**YES** ☐**NO** # nights in the past month?_____
4. Do you use a rescue medicine for asthma symptoms? ☐**YES** ☐**NO** **N**ame_____
   a) In the *past 4 weeks,* did you use it at least twice/week? ☐**YES** ☐**NO**
   b) In the *past 4 weeks*, what was the average number of times per week you used it? _____
   c) In the *past 4 weeks*, what is the highest number of times you used it in 1 day? _____
5. Do you use a daily controller medication for asthma? ☐**YES** ☐**NO**
   a) In the *past 4 weeks*, what was the average number of times per week you used it? _____
   b) In the *past 4 weeks*, do you feel your asthma has been well controlled? ☐**YES** ☐**NO**
   c) Do you think the medication is controlling your asthma symptoms? ☐**YES** ☐**NO**
6. Are you dissatisfied with any part of your current asthma treatment? ☐**YES** ☐**NO**
   If yes, please explain_____
7. During this office visit, what would you like to discuss regarding your asthma?
   a) Your preferences regarding asthma medications? ☐**YES** ☐**NO**
   b) Your asthma treatment plan? ☐**YES** ☐**NO**
   c) Other issues? _____ ☐**YES** ☐**NO**
8. How many asthma attacks have you had in the past year? _____ How many days missed from school or work because of asthma in the past year? _____