Patient follow up visit

ASTHMA PRE-VISIT QUESTIONNAIRE

Patient Name: _____

Date: _____

Date of Birth: _____ Age: _____

Before your visit with Dr. _____ to discuss your child's asthma, please take a moment to fill out the form below. Thank you.

Frequency of Symptoms

1. Number of days in the last 2 weeks with daytime coughing, wheezing, Shortness of breath (SOB) or tightness in chest:
2. Number of nights in the last month with coughing, wheezing, SOB or tightness in chest:
3. Number of times in the last week needed quick-relief asthma medication for coughing, wheezing, SOB:
4. Number of times asthma symptoms interfered with activity in past 2 weeks:
5. Date of last asthma attack, flare-up or exacerbation:
6. Number of missed school days due to asthma in the past month:
7. Number of days parent/guardian/caregiver lost work due to child's asthma in the past month:
8. Number of hospitalizations for asthma symptoms in the last 6 months:
9. Number of visits to the ED for asthma symptoms in the last 6 months:
10. Number of visits to this or any other clinic because of acute asthma symptoms in the last 6 months:

Influenza vaccine (please circle)

11. Has the patient had an influenza vaccine in the last 12 months? **Yes** **No** **Not Sure**

Equipment (please circle)

12. Patient has a nebulizer machine: **Yes** **No** **Not Sure**
13. Patient has a spacer: **Yes** **No** **Not Sure**
14. What other concerns do you have regarding your child's asthma that have not yet been discussed?

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_____

*Adapted from Asthma Environmental History Form, NEEF https://www.neefusa.org/resource/asthma-environmental-history-form
Reference: Environmental Management of Pediatric Asthma: Guidelines for Health Care Providers www.neefusa.org/resource/environmental-management-pediatric-asthma-guidelines-health-care-providers