Asthma Questionnaire for Parents

Date _____

Child's Name_____ Grade_____ DOB _____

Parent's Name _____

Name of Doctor treating Asthma _____

Name of Clinic_____ Clinic Phone_____

Hospital preference (in case of emergency) _____

1. At what age was your child's asthma diagnosed? _____

2. How severe is your child's asthma?

□ Mild
□ Moderate
□ Severe

3. What are your child's usual signs/symptoms during as asthma attack?

❑ Wheezing	❑ Cough	❑ Difficulty Breathing
❑ Chest tightness	❑ Anxiety	❑ Other (please describe)

4. How many days of school would you estimate your child missed last year due to asthma? _____

5. In the past year, how many times has your child been treated in the emergency room for asthma symptoms? _____

6. In the past year, how many times has your child been hospitalized (overnight or longer) for asthma symptoms? _____

7. In the past month, during the day, how often has your child had asthma symptoms? _____

8. In the past month, during the night, how often does your child wake up or experience asthma symptoms?_____

9. What triggers your child's asthma symptoms?

□ Exercise
□ Stress/Illness
□ Cold air
□ Allergies to _____
□ Smoke (Does anyone smoke at home?_____
□ Other_____

Please complete other side →

10. What does your child do at home to relieve the symptoms during an attack?

□ Rests
□ Drinks fluids
□ Uses breathing exercises
□ Checks peak flow
□ Takes medication
□ Other_____

11. Does your child have an Asthma Action Plan (a written treatment plan created by your doctor and specific to your child)? **If yes, please include a copy.**

□ Yes
□ No
□ Don't know

12. What medications is your child using presently to control or treat asthma symptoms?

Name of medication	How much?	How often?

13. Does your child know when he/she needs medication?

□ Yes
□ No

14. If your child uses an inhaler, does he/she use a spacer?

□ Yes
□ No

15. Has your child had asthma education?

□ Yes
□ No

Comments:

Parent Signature_____ Date_____