# Health Assessment Asthma Questionnaire

| | YES | NO |
|---|---|---|
| 1. Has your child been admitted to the hospital or visited the emergency department for asthma related illness in the past 3 years? | ◯ | ◯ |
| 2. Has your child been prescribed oral steroids in the last 6 months? | ◯ | ◯ |
| 3. Does your child have difficulty recognizing asthma symptoms? | ◯ | ◯ |
| 4. Does your child have a primary care physician managing their asthma? | ◯ | ◯ |
| 5. Does anyone smoke in your home? | ◯ | ◯ |
| 6. Does your child have a history of anaphylaxis, cardiovascular disease, chronic psychiatric disorders or other chronic lung disease? | ◯ | ◯ |
| 7. Does your child requires asthma medication (rescue inhaler) more than once a week? | ◯ | ◯ |

Please return to the health room

Student Name: _____DOB:_____School:_____Grade:_____