PATIENT ASTHMA QUESTIONNAIRE

Patient Name: ______________________
Date of birth: ____/____/____
Sex: ___M___F___
Insurance: ______________________

	Yes	No	Don't Know	Provider Comments
Are you currently exposed to tobacco smoke in the following situations?				
As a smoker?	☐	☐	☐	Dates of advice/referrals to quit:
At home	☐	☐	☐	
At work	☐	☐	☐	
In the car	☐	☐	☐	
Other: ____________	☐	☐	☐	
Are you allergic to any of the following?				
Medicines (e.g. aspirin)	☐	☐	☐	List:
Food	☐	☐	☐	
Animals	☐	☐	☐	
Mold	☐	☐	☐	
Pollen	☐	☐	☐	
Dust/dustmites	☐	☐	☐	
Cockroaches	☐	☐	☐	
Other: ____________	☐	☐	☐	
Do any of the following items trigger your asthma? *(Cause you to cough, wheeze, have shortness of breath or chest tightness)*				
Air pollutants	☐	☐	☐	
Weather	☐	☐	☐	
Infections	☐	☐	☐	
Food additives (e.g. sulfites)	☐	☐	☐	
Emotions such as laughing, crying, anger, etc.	☐	☐	☐	
Exercise	☐	☐	☐	
Tobacco	☐	☐	☐	
Aerosol sprays	☐	☐	☐	
Other: ____________	☐	☐	☐	
Have you ever:				
Been hospialized for asthma?	☐	☐	☐	Intubated?
Been treated in the ER for asthma?	☐	☐	☐	Frequency?
Attended educational classes about asthma?	☐	☐	☐	Dates:
Seen an asthma specialist?	☐	☐	☐	Name:
				Date seen:
During the last month have you had any of the following symptoms?				
Interrupted sleep	☐	☐	☐	
Coughing	☐	☐	☐	
Wheezing	☐	☐	☐	
Shortness of breath	☐	☐	☐	
Chest tightness		☐	☐	☐
Runny nose (seasonal)	☐	☐	☐	
Itchy eyes	☐	☐	☐	
Heartburn	☐	☐	☐	
Other: ____________	☐	☐	☐	Dates of Oral Steroids:
Do you need any of the following to help you better manage your asthma?				
Transportation to get to appointments	☐	☐	☐	
Prescription coverage	☐	☐	☐	
Other: ____________	☐	☐	☐	
Other Information				
Do any of your family members have asthma?	☐	☐	☐	
Do you have any other medical conditions?	☐	☐	☐	List:
Do you currently take any medications?	☐	☐	☐	List:

PHYSICAL EXAM

Skin:		ENT:	
Cardiac:		Chest:	
Other:			

DIAGNOSICS

	Date and Results	Date and Results	Date and Results
Allergy tesing			
Chest Xray			
PFTs			
Peak flow baseline *(Asymptomatic personal best)*			
Today's peak flow			

PPD *(Annual with ongoing prednisone):*

Results:							
Date:							

ASSESSMENT: *(Classification from NHLBI guidelines — additional dates listed in event of future changes.)*

	Date	Date	Date	Symptoms	Nighttime Symptoms	Lung Function
Severe Persistent				☐ Continual symptoms ☐ Limited physical activity ☐ Frequent exacerbations	Frequent	☐ FEV1 or PEF ≤60% predicted ☐ PEF variability >30%
Moderate Persistent				☐ Daily symptoms ☐ Daily use of inhaled short-acting beta2-agonist ☐ Exacerbations >2 times a week; may last days	>1 time a week	☐ FEV1 or PEF>60% -<80% predicted ☐ PEF variablity >30%
Mild Persistent				☐ Symptoms >2times a week but <1time a day ☐ Exacerbations may affect activity	>2 times a month	☐ FEV1 or PEF >80% predicted ☐ PEF variability 20-30%
Mild Intermittent				☐ Symptoms < 2 times a week ☐ Asymptomatic (and normal PEF between exacerbations) ☐ Exacerbations brief (from a few hours to a few days); intensity may vary	<2 times a month	☐ FEV1 or PEF >80% predicted ☐ PEF variability <20%

Barriers to Care (circle all that apply): Transportation Prescription coverage Environmental controls Resistant to taking medications
Other: ______________________

PLAN

Long-term control medications

Medication type	Name	Dose	Comments
Corticosteroids			
Cromolyn sodium and Nedocromil			
Long acting beta2-agonists			
Methylxanthines			
Leukotriene modifiers			

Quick-relief medications

Medication type	Name	Dose	Comments
Short-acting Beta2-Agonists			
Anticholinergics			
Systemic corticosteroids			

Knowledge/skill	Date Received	Date scheduled	Educator	Adequate? Yes	Adequate? No
Health Education/Skills*					
Introduction to asthma (what is asthma?)				☐	☐
Triggers				☐	☐
Deep breathing and relaxation techniques				☐	☐
Early warning signs/when to call physician				☐	☐
Written action plan (emergency plan)				☐	☐
*Inhaler use				☐	☐
Spaceholding chamber use				☐	☐
*Peak flow monitoring/daily diary				☐	☐
Prevention Measures (irritant/allergen control)*					
Cases for bedding and washing				☐	☐
Air filter				☐	☐
Vacuum cleaner (double bags/HEPA filter)				☐	☐
Dryer vent to outside				☐	☐

Evidence based

CHRONIC ASTHMA FLOW CHART

(+) = positive finding
(-) = negative finding
(blank) = not asked/examined

Patient Name: ____________________
Date of birth: ____/____/____
Sex: M F
Insurance: ____________________

Dates: ________ ________ ________ ________ ________

SUBJECTIVE:

Cough					
Wheeze					
Shortness of breath					
Chest tightness					
Feverish					
Chills					
Other:					

OBJECTIVE:

Respiratory rate					
HEENT					
Chest					
Wheezes					
Ronchi					
Rales					
Intercostal retractions					
Accessory muscle use					

DIAGNOSTICS:

Peak Flow					
02 Saturation (prn)					

ASSESSMENT:

Classification by NHLBI Guidelines (Reclassify annually) *(Severe Persistent, Moderate Persistent, Mild Persistent, Mild Intermittent)*					
Today's condition *(Excellent +4, Good 3+, Fair 2+, Poor 1+)*					
Self assessment *(Excellent +4, Good 3+, Fair 2+, Poor 1+)*					

PLAN (Medications):

TYPE	NAME	DOSAGE					
Inhaled B-agonist							
*Inhaled Steroid							
Cromolyn							
Leukotriene modifiers							
Prednisone							
Other:							

PLAN (Behavioral Objectives): Fill in A=Adequate, I=Inadequate, blank=Not Done)

Verbalized early signs of deterioration and actions needed	*A, I, ND*				
*Demonstrates monitoring of peak flow meter					
*Demonstrates correct inhaler and spacer technique					
*Demonstrates understanding and use of action plan					
Environmental controls in place -*Washes sheets and blankets in hot water weekly* -*Uses dustmite covers for mattress/pillows etc.*					

Patient's Goals of Treatment: ____________________

Vaccinations: DATES: ______ ______ ______ ______ ______ ______ ______

Flu Shot (annual)							
Pneumoccocal							

**Evidence based*