

Date _____
Initials _____**ASTHMA SCREENING QUESTIONNAIRE**

1. Child's Name _____ 2. D.O.B. ____ / ____ / ____
3. HS Program _____ 4. Gender M F
5. Parent's Name _____ 6a. Phone #(s) _____
- 6b. Phone #(s) _____ 6c. Phone #(s) _____
7. Ethnic Background _____ 8. Language English Other
9. Number of Adults Living in the Home: _____ 10. Number of Children Living in the Home: _____
11. **Has your child ever been diagnosed with asthma?** 1) Yes 2) **No--if [no] skip to question 23**
- 11a. If yes, at what age was the asthma or wheezy bronchitis diagnosed?
11b. Where/Who diagnosed the asthma?
11c. Has your child had asthma symptoms in the past year? 1) yes 2) no
12. Has your child ever been hospitalized because of asthma? 1) yes 2) no
- 12a. If yes, when? (List all admissions)
12b. ICU admission? _____
13. Has your child ever had any emergency room visits for asthma? 1) yes 2) no
- 13a. If yes, were any of the visits in the last year? 1) yes 2) no
13b. List all ER visits for asthma (Dates/Locations)
14. Has your child seen a doctor within the last year due to an asthma episode? 1) yes 2) no
- 14a. If yes, when?
14b. where?
14c. which M.D.?
14d. Has your child ever been diagnosed with RSV? 1) yes 2) no; If yes, Date:
15. Are you currently employed? 1) yes 2) no
- 15a. If yes, have you or another parent missed any work days in the last year due to the child's asthma episode(s)?
1) yes 2) no
15b. If yes, how many days?
16. Has your child been enrolled in preschool or day-care in the past year? 1) yes 2) no
- 16a. If yes, any absences due to asthma? 1) yes 2) no
16b. If yes, how many days in the past year? _____
17. During the past 6 months, how often has your child had an asthma episode or breathing problems?
1) daily 2) $\geq 1-2x/week$ 3) $\geq 1-2x/month$ 4) only with a cold/virus 5) Other
- 17a. In general, how would you describe the severity of these episodes?
1) mild 2) moderate (interferes with sleep/play) 3) severe (requires some type of response/meds)
- 17b. What factor(s) usually trigger your child's asthma episodes? 1) colds/infections 2) cigarette smoke
3) heat/humidity 4) cold weather 5) dust 6) pollens/allergies 7) exercise
8) Other
18. Check all medications the child is **currently** taking:
- 1) Albuterol Syrup (Proventil/Ventolin) Dose
2) Albuterol Solution for Nebulization (Proventil/Ventolin) Dose
3) Albuterol Metered Dose Inhaler [Puffer] (Proventil/Ventolin) Dose
4) Budesonide Respules for Nebulization Dose
5) Inhaled steroids (Azmacort/Beclovent/Vanceril/Aerobid/Flovent/Pulmicort) Dose
6) Oral steroids (Prelone, Pediapred) Dose
7) Theophylline (Slo-phyllin/Choledyl/Elixophyllin) Dose

- 8) Nedocromil/Cromolyn Dose
 9) Leukotriene Modifier (Accolate/Singulair) Dose
 10) Over-The-Counter cough/cold prep. (Name: _____ Dose: _____)
 11) Other

19. Has the child **ever** used oral/liquid steroids (Pediapred, Prelone) to treat asthma? 1) yes 2) no
 19a. If yes, number of times in past year?
20. Does the child have a nebulizer at home? (a machine that makes liquid drug into a mist) 1) yes 2) no
 20a. Is the machine in working order? 1) yes 2) no
 20b. Do you have nebulizer supplies currently? 1) yes 2) no
21. Does the child have an inhaler spacer at home? 1) yes 2) no
 21a. If yes, what kind of spacer do you have? _____
22. How confident do you feel in managing your child's asthma?
 1) Not at all 2) A little 3) Fairly 4) Completely/Very

IF NO TO ASTHMA DIAGNOSIS:

23. Does your child have any breathing problems? 1) yes 2) no
 23a. ➔ If yes, what type? _____
24. Does your child ever have wheezy/noisy breathing? 1) yes 2) no
 24a. If yes, when? daytime nighttime once a week twice a week with a cold
 24b. If yes, what do you do? _____
25. Does your child cough a lot when he/she does not have a cold? (at night, while playing?) 1) yes 2) no
 25a. If yes, what medicine do you use to treat the cough? _____
26. Has your child **ever** used albuterol syrup, inhaler, or breathing treatment (Proventil/Ventolin) for wheezing, coughing, or breathing problems? 1) yes 2) no
 26a. If yes, when was the last time, Date: _____

ASK ALL PARENTS QUESTIONS 27-36:

27. Does your child have any brothers or sisters with asthma? 1) yes 2) no
 27a. If yes, please list genders & ages:
28. Does either parent have asthma? 1) _____ Mother 2) _____ Father 3) no
29. Does your child have allergies? (environmental, foods, drugs) 1) yes 2) no
 29a. List allergic triggers
 29b. Has your child ever been skin tested for allergies? 1) yes 2) no
30. Does anyone that stays in the home smoke? 1) yes 2) no
 30a. If yes, how many cigarettes/day? _____
 30b. Where: Inside Outside Both
 30c. Did mother smoke during pregnancy? 1) yes 2) no
31. At what age did your child begin using day care services? _____
32. Does your home every smell musty or damp? 1) yes 2) no
33. Have you ever seen mold in your home? 1) yes 2) no
34. Does your child's bedroom have carpeting? 1) yes 2) no
35. Have you ever seen cockroaches in your home? 1) yes 2) no
36. Are there any pets in the home? 1) yes 2) no
 36a. If yes, please list: _____