

Date: _____
Initials: _____
Subject ID: _____

BRIEF ASTHMA SCREENING QUESTIONNAIRE

1. Child's Name: _____ 2. H.S. Program: _____
3. Parent's Name: _____ 4. Gender: M F
5. D.O.B. _____ 6. Phone: (h) _____
7. Ethnic Background: _____ (w) _____
8. Primary Language: _____ (o) _____

9. **Has your child ever been diagnosed with asthma?** Yes No

Please continue for ALL enrolling children:

About your child's breathing

10. Does your child have any breathing problems? Yes No
a. If yes, what type? _____
11. Does your child ever have wheezy or noisy breathing? Yes No
a. If yes, when? Daytime Nighttime Once a Week Twice a Week With a cold
b. If yes, what do you do? _____
12. Does your child cough a lot when he/she **DOES NOT** have a cold? (at night, while playing?) Yes No
a. If yes, what medicine do you use to treat the cough? _____
13. Has your child **ever** used **albuterol** syrup, inhaler, breathing treatment (Ventolin®, Proventil®) for wheezing, coughing or breathing problems? Yes No
(If "YES", please circle type of albuterol treatment used.)

About your family history

14. Does your child have any **brothers** or **sisters** with asthma? Yes No
a. If yes, please list genders and ages: _____
15. Does either **parent** have asthma or allergies? No Yes
Mother Asthma Yes No **Allergies** Yes No If "YES", please list: _____
Father Asthma Yes No **Allergies** Yes No If "YES", please list: _____
16. Does your child have any allergies? (environment, foods, drugs) Yes No
a. If yes, please list: _____

About your child's environment (where your child stays)

17. Does anyone that stays in the home smoke? Yes No
a. If yes, how many cigarettes/day? _____
b. Where? Inside Outside Both
18. Did mother smoke during pregnancy? Yes No
19. At what age did your child start using day care services? _____
20. Does your home ever smell musty or damp? Yes No
21. Have you ever seen mold in your home? Yes No
22. Does your child's bedroom have carpeting? Yes No
23. Have you ever seen cockroaches in your home? Yes No
24. Are there any pets in the home? Yes No
If yes, please list: _____
24. How many people live in your home?
Adults: _____ # Children: _____