

Asthma Questionnaire for Parents

Child's Name _____ Grade _____

Parent's Name _____

Name of Doctor treating asthma _____

Name of Clinic _____ Clinic Phone _____

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 an asthma attack?

wheezing cough difficulty breathing

chest tightness anxiety other _____

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 cold air illness

allergies to _____

smoke (Does anyone smoke at home? _____)

other _____

Please complete back side also!

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

- rests
 drinks fluids
 uses breathing exercises
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

A blank Asthma Action Plan is included with this questionnaire. Please complete it with your child's doctor and return to school with any medication that may be needed while at school

12. What medications is your child using presently to control or treat asthma symptoms? (Sometimes or all the time)

Name of medication	How much?	How often?