Asthma Data Collection Form – 2014

Ohio Valley Primary Care Associates | Tri State Child Health Services, Inc. | Cincinnati Children's Hospital Medical Center

Patient Name: _____, Date of Birth: ____/____/____, Physician Name:_____

Patient E-mail: _____, Insurance Company: _____, Date of Visit: ____/____/____

☐ asthma well visit ☐ asthma sick visit ☐ asthma sick visit follow up ☐ phone visit ☐ other visit

PARENT SECTION - Please Complete Questions 1-15. Thank you for helping us care for your child

1. How many days of school/daycare has your child missed **due to asthma** in the **past 6 months?** ____ # of days ☐ Does not attend
2. How many work days have you or your spouse missed **due to your child's asthma** in the **past 6 months?** ____ # of days ☐ Does not apply
3. Has your child visited the Emergency Room or Urgent Care Center **due to asthma** in the **past 12 months?** ☐ YES ☐ NO
4. Has your child been admitted to the hospital **due to asthma** in the **past 12 months?** ☐ YES ☐ NO
5a. How comfortable are you taking care of your child with asthma when he/she is sick or well?

Not Comfortable = ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **= Very Comfortable**

5b. What would make you feel more comfortable/confident? _____

6. During the **past 4 weeks**, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or reduced activity **due to asthma during the *DAY*?** ☐ ≤ to 2 days / week ☐ > 2 days / week but not daily ☐ Daily ☐ Throughout the day
7. During the **past 4 weeks**, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or waking up **due to asthma at *NIGHT*?** ☐ ≤ 2 times / month ☐ 3-4 times a month ☐ > 1 time / week but not nightly ☐ Often 7 times / week
8. During the **past week**, how often did your child need a fast acting or quick relief medication (Rescue Inhaler) at times **other than before exercise**? (includes Albuterol, Ventolin®, Proventil®, Xopenex®)

☐ Not sure ☐ Not at all ☐ Less than 1 time per day ☐ 1-3 times per day ☐ 4 or more times per day

9. Does your child use a spacer with his/her inhaler? ☐YES ☐NO ☐ Not sure
10. When are **asthma** symptoms worse? (***Check all that apply***) ☐Winter ☐Spring ☐Summer ☐ Fall ☐ All ☐ None
11. Please mark **all** things that make your child's **asthma** worse:

☐ Respiratory Infections ☐ Irritants (Tobacco Smoke, Wood Smoke, Air Pollution, Perfumes, Incense, Other Irritant)
☐ Changes in Weather ☐ Allergens (Animals, Dust, Pollen, Mold, Food) ☐ Exercise/Increased Activity ☐ Heat/Humidity ☐ Cold Air
☐ Other: _____ ☐ Don't know ☐ None

12. How often does asthma limit your child's activities?

☐ Not at all ☐ A little of the time ☐ Some of the time ☐ Most of the time ☐ All of the time

13. How would you rate your child's asthma control during the **past month**? ☐ *Well controlled ☐ Not well controlled ☐ Very poorly controlled
14. Are you planning to have your child receive the flu vaccine this flu season? ☐ YES ☐ NO-reason: _____
15. Are there things **about your child's asthma** you want to discuss with your physician today?

PHYSICIAN SECTION – Please Complete Questions 16-23

16. Was a recommendation made for the patient to receive the flu vaccine? ☐ YES ☐ NO
17. Asthma severity level: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
18a. Is the patient on a controller medication?
☐ YES ➔ ☐ Seasonal use ☐ Continuous use
☐ Started this visit ➔ ☐ Seasonal use ☐ Continuous use
☐ NO
18b. If YES, does the patient/parent report using controller medications daily (applies to seasonal and continuous use)? ☐ YES ☐ NO
19. Has the patient received oral steroids for bronchospasm within the **past 12 months?** ☐ YES ☐ NO
20a. Does the patient have a written asthma action plan? ☐ YES ☐ NO
20b. If YES, was the plan updated as needed and reviewed with the patient and/or family at this visit? ☐ YES ☐ NO
21. Has the patient been seen by an allergist or pulmonologist during the **last 12 months** for assistance with asthma management due to severity of illness? ☐ YES ☐ NO ☐ Referred this visit Specialist: _____
22. How would you rate the patient's asthma control during the **past month**? ☐ *Well controlled ☐ Not well controlled ☐ Very poorly controlled
23. Has the patient had spirometry within the past 1 ~ 2 years? ☐ YES: date____/____/_____ ☐ NO ☐ N/A due to age

(Per Guidelines for the Diagnosis and Management of Asthma; National Heart, Lung, and Blood Institute; 2007)

Follow-up visit: Return in: ___ weeks, or ___ months (Return visit date: _____ / _____ / _____)

***Well controlled asthma** is defined as ♦symptoms ≤ 2 days/week, ♦nighttime awakenings ≤ 1 time/month, ♦no interference with normal activity, ♦ short acting beta$_2$ agonist use for symptom control ≤ 2 days/week (not prevention of exercise-induced bronchospasm), ♦ exacerbations requiring oral systemic corticosteroids 0~1/year ♦ FEV_1 or peak flow > 80% predicted value or personal best.
(Guidelines for the Diagnosis and Management of Asthma; National Heart, Lung, and Blood Institute; 2007)