

ASTHMA DATA COLLECTION FORM

Patient Name:	Provider Name:
Date of Birth:	Practice Name:
Date of Visit:	Other Patient Identifier (office use):
Date of Last Asthma Visit (month/year):	Insurance Company:

Parents – Please complete the following section:

<p>1. Has your child visited the Emergency Room or Urgent Care due to asthma in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has your child been admitted to the hospital due to asthma in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. How many days of work have you and/or your spouse missed due to your child's asthma since your last asthma visit?</p> <p>4. How many days of school has your child missed due to asthma since your last asthma visit?</p> <p>5. Is your child exposed to cigarette smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. How confident are you in your ability to manage your child's asthma? (Please Mark One) <input type="checkbox"/> Not Confident <input type="checkbox"/> Somewhat Confident <input type="checkbox"/> Very Confident</p> <p>7. How frequently has your child experienced episodes of cough, shortness of breath, wheeze, chest tightness, or reduced activity due to asthma since your last asthma visit? During the DAY: <input type="checkbox"/> Once per day <input type="checkbox"/> 3-6 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Less than twice per month During the NIGHT: <input type="checkbox"/> Once per day <input type="checkbox"/> 3-6 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Less than twice per month</p> <p>8. Does your child have recurrent nose and/or eye symptoms (running nose, nose rubbing, sneezing) in the spring or fall? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8a. If 'Yes', is your child's asthma worse when this occurs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. How would you rate your overall satisfaction with your child's asthma care? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p>	<div style="border: 1px solid black; height: 40px; margin-bottom: 10px;"></div> <div style="border: 1px solid black; height: 40px;"></div>
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Please DO NOT complete anything beyond this point. The opposite side of the page is for OFFICE USE ONLY.