Cincinnati Children's

Tri State Child Health Services, Inc.

Ohio Valley Primary Care Associates

Patient Name: _____

Date of Birth: ____/____/____ Date of Visit: ____/____/____

Insurance Company: _____

Asthma Data Collection Form

(Provider Name)

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

PARENT SECTION - Please Complete Questions 1-12

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
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
5. How comfortable are you in your ability to manage your child's asthma, rated on a scale of 1-10? (Please circle)
   Not Comfortable = 1 2 3 4 5 6 7 8 9 10 = Very Comfortable
6. During the **past month**, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or reduced activity **due to asthma during the *DAY***?
   ☐ More than once per day ☐ Once per day ☐ 3-6 days per week ☐ 0-2 days per week
7. During the **past month**, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or waking up **due to asthma at *NIGHT***?
   ☐ 7 or more nights per month ☐ 5-6 nights per month ☐ 3-4 nights per month ☐ 0-2 nights per month
8. During the **past week**, how often did your child use a fast acting or quick relief medication, at times **other than before exercise**? (includes Albuterol, Ventolin®, Proventil®, Xopenex®)
   ☐ not at all ☐ less than 1 time per day ☐ 1-3 times per day ☐ 4 or more times per day ☐ not sure
9. When are asthma symptoms worse? (**Check all** that apply)
   ☐ winter ☐ spring ☐ summer ☐ fall ☐ during exercise
10. 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
11. How would you rate your child's asthma control during the **past month**?
    ☐ not controlled at all ☐ poorly controlled ☐ somewhat controlled ☐ well controlled ☐ completely controlled
12. Are you planning to get a flu shot for your child? ☐ YES ☐ NO-reason: shot date: ___/___/_____

PHYSICIAN SECTION – Please Complete Questions 13-20

☐ Asthma diagnosis tentative

13. Asthma severity level: ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Mild Intermittent
14. Is the patient on a controller medication? ☐ YES ☐ NO
    If YES, does the patient/parent report using controller medications daily? ☐ YES ☐ NO ☐ Started this visit
15. For patients who use rescue/controller inhalers, is a spacer utilized? ☐ YES ☐ NO
    (Maxair® and dry powder inhalers do not require spacer)
16. Has the patient received oral steroids for bronchospasm within the **past 12 months**? ☐ YES ☐ NO
17. Does the family have a copy of a written asthma management plan from a primary care physician or specialist? ☐ YES ☐ NO
    If YES, please review with family and update, as needed.
18. 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? Specialist: _____ ☐ YES ☐ NO ☐ Referred this visit
19. How would you rate the patient's asthma control during the **past month**?
    ☐ not controlled at all ☐ poorly controlled ☐ somewhat controlled ☐ well controlled ☐ completely controlled*
20. Has the patient had spirometry within the past 12 months? ☐ YES: date____/____/_____ ☐ NO

*Complete or total control of asthma is defined as **no** asthma symptoms; **no** rescue bronchodilator use; **no** nighttime or early morning awakening; **no** limitations on exercise, work or school; **complete** control of asthma by patient **and** physician assessment; and **normal or personal best** PEF or FEV_1. (Joint Task Force on Practice Parameters for Allergy & Immunology – AAAI, ACAI, pub. Nov. 2005)

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

(Revised 6/06)