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)

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<tr>
<th>Name of medication</th>
<th>How much?</th>
<th>How often?</th>
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