



ASTHMA DATA COLLECTION FORM

Patient Name:	Provider Name:
Date of Birth:	Other Patient Identifier (office use):
Date of Visit:	Insurance Company:

Parents – Please complete the following section:

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	
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	
3. How many days of work have you and/or your spouse missed due to your child's asthma since your last asthma visit?	<input type="text"/>
4. How many days of school has your child missed due to asthma since your last asthma visit?	<input type="text"/>
5. 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	
6. 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	
7. 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	
8. 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	

Please DO NOT complete anything beyond this point. The opposite side of the page is for OFFICE USE ONLY.

Patient Name:		Patient Status: <input type="checkbox"/> Active <input type="checkbox"/> Exempt
Date of Birth:	Date of Visit:	Reason for Exempt: <input type="checkbox"/> Lung disease of prematurity
Assigned PCP:		<input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Significant cardiac abnormalities
Provider Seen Today:		<input type="checkbox"/> Significant neuromuscular disorder
		<input type="checkbox"/> Other: _____

Providers – Please complete the following sections:

<p>1. How would you classify the patient's asthma severity? (please check one) <input type="checkbox"/> Persistent <input type="checkbox"/> Intermittent <input type="checkbox"/> EIB (Intermittent)</p> <p>2. Is the patient on controller medication? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> Refused If 'Yes' please complete Medications section below.</p> <p>3. Has the patient been on rescue oral steroids in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. How many times has the patient been to the ER or Urgent Care due to asthma in the last 6 months? <input type="text"/></p> <p>5. How many times has the patient been hospitalized due to asthma in the last 6 months? <input type="text"/></p> <p>6. Have you obtained a pulmonary function test on this patient in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred</p> <p>7. Does the patient see an asthma specialist as part of their regular care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred</p> <p>8. What was the date of the patient's last influenza vaccination? ____/____/____</p> <p>8a. If the patient did not have an influenza vaccination is the patient contraindicated or did they actively refuse? <input type="checkbox"/> Contraindicated <input type="checkbox"/> Refused</p>

Medications

Please complete/update the following information regarding controller medications	<u>Notes:</u>
Inhaled Corticosteroid <input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue	
Inhaled Corticosteroid with Long Acting Beta Agonist <input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue	
Leukotriene Antagonists <input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue	
Other <input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue	

Counseling

<p>Does this patient have an asthma action plan (created by a primary care provider or a specialist) that has been reviewed/created at this visit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient/family been counseled on MDI technique, spacer, and/or nebulizer use at this visit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient exposed to cigarette smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'Yes', did you provide counseling regarding cigarette smoke exposure at this visit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--