

# Asthma Questionnaire

Name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Member #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Thank you for taking the time to complete this questionnaire. Your answers are important and will help us to meet your health care needs. This questionnaire will take about 10 minutes to finish.**

## General Information

1. What is your address and best contact telephone number?  
 \_\_\_\_\_ (Address) (City, State, Zip code) ( ) \_\_\_\_\_ (Phone number)
2. Do you live:  alone  spouse or partner  
 (please check all that apply)  parent/guardian  other non-family members
3. What is your primary language? Do you need an interpreter? Yes No Don't know
4. What is the name of the doctor or care provider you see most? \_\_\_\_\_  
 Clinic Name/Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_
5. Have you ever seen a specialist for your asthma? Yes No Don't know  
 If yes: Name/Specialty: \_\_\_\_\_

## General Health Information

6. Are there any other medical problems you are being treated for? Yes No Don't know  
 If yes, please explain: \_\_\_\_\_
7. In the past few weeks, have you felt down, depressed or hopeless? Yes No Don't know  
 If yes, please explain: \_\_\_\_\_
8. In the past 2 weeks, have you lost interest in doing things you have enjoyed in the past? Yes No Don't know
9. Are you experiencing any pain at this time? Yes No Don't know  
 If yes, where? \_\_\_\_\_
- On a scale of "0" to "10" how would you rate your pain?  
 (where "0" is no pain, "5" is moderate pain, and "10" is the worst pain you've ever had)  
 0  1  2  3  4  5  6  7  8  9  10
10. Have you had a flu shot? Yes No Don't know  
 If yes, what was the date of your last shot? \_\_\_\_\_
11. Have you had a pneumonia shot? Yes No Don't know  
 If yes, what was the date of your last pneumonia shot? \_\_\_\_\_
12. In the last 6 months, have you been to the emergency room (ER) or hospital for asthma? If yes, how many times? \_\_\_\_\_ Yes No Don't know

**Medication and Asthma Information**

13. What prescription medications do you take?  
Please list: \_\_\_\_\_
14. Do you take non-prescription medications or supplements (for example, aspirin, vitamins, etc.)? If yes, please list: \_\_\_\_\_
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
15. In the past 6 months, have you taken oral steroids for your asthma (for example, prednisone)?
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
16. Have you been taking your medications as prescribed by your doctor?  
If no, why not? \_\_\_\_\_
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
17. Are you having any problems taking your medications?  
If yes, please explain: \_\_\_\_\_
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
18. Do you use more than one type of inhaler?  
If yes, please list them: \_\_\_\_\_
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- How often do you get a new inhaler? \_\_\_\_\_
- How often do you use your inhaler(s)? \_\_\_\_\_ times per:  day  week (or)  month
19. Do you use a spacer for your inhaler?
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
20. Do you use a nebulizer?
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
21. Do you use a peak flow meter to monitor your asthma?  
If yes, what is your personal best peak flow reading? \_\_\_\_\_
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
22. Do you have a written Asthma Action Plan?
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
23. Do any of the following triggers bring on or make your asthma worse? (Check all that apply):
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pets/Feathers/Dander           | <input type="checkbox"/> Change of Seasons                  | <input type="checkbox"/> Weather/Cold air     |
| <input type="checkbox"/> Cold/Flu/Respiratory infection | <input type="checkbox"/> Dust or Mold                       | <input type="checkbox"/> Pollen               |
| <input type="checkbox"/> Fireplace Smoke                | <input type="checkbox"/> Smoking/2 <sup>nd</sup> hand smoke | <input type="checkbox"/> Perfume/Strong odors |
| <input type="checkbox"/> GERD or Heartburn              | <input type="checkbox"/> Exercise                           | <input type="checkbox"/> Stress               |
| <input type="checkbox"/> Other _____                    |   |   |
24. Are you currently having any wheezing, shortness of breath, chest discomfort or cough?
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
25. In the past month, have you had nighttime coughing or wheezing more than twice a week?
- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Don't know               |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
26. Has your asthma affected your ability to perform your usual daily activities?  
Please explain: \_\_\_\_\_
- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
|  | Not at all               | Sometimes                | Often                    | Always                   |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

# Asthma Questionnaire

Additional Information						
27. Would you like to participate in our asthma educational program?	Yes	No	Don't know			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
(This a free benefit that is offered by Community Health Plan of WA. No classes or travel are required. A nurse will call you on the telephone)						
What days are best to call you?	Mon	Tue	Wed	Thu	Fri	Any Day
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What are the best times to call you?	<input type="checkbox"/> 7-9 am	<input type="checkbox"/> 9-11 am	<input type="checkbox"/> 11 am-1 pm			
	<input type="checkbox"/> 1-3 pm	<input type="checkbox"/> 3-5 pm	<input type="checkbox"/> Anytime			
28. Is there anything else we can do to help you?	Yes	No	Don't know			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

**Thank you for answering these questions.**

**Please return this completed form in the self-addressed, stamped envelope provided and one of our Disease Management Nurses will contact you. As part of this program, we will mail educational materials to you to help you manage your asthma.**