

# 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
15. In the past 6 months, have you taken oral steroids for your asthma (for example, prednisone)? Yes  No  Don't know
16. Have you been taking your medications as prescribed by your doctor? If no, why not? \_\_\_\_\_ Yes  No  Don't know
17. Are you having any problems taking your medications? If yes, please explain: \_\_\_\_\_ Yes  No  Don't know
18. Do you use more than one type of inhaler? If yes, please list them: \_\_\_\_\_ Yes  No  Don't know
- 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
20. Do you use a nebulizer? Yes  No  Don't know
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
22. Do you have a written Asthma Action Plan? Yes  No  Don't know
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
25. In the past month, have you had nighttime coughing or wheezing more than twice a week? Yes  No  Don't know
26. Has your asthma affected your ability to perform your usual daily activities? Not at all  Sometimes  Often  Always   
Please explain: \_\_\_\_\_

**Additional Information**

## Asthma Questionnaire

Community **HealthFirst**<sup>™</sup>  
Medicare Advantage Plans



27. Would you like to speak with one of our health educators about any asthma related questions you may have? Yes  No  Don't know
- Which days are best for you? Mon  Tue  Wed  Thu  Fri  Any Day
- What are the best times to reach you?  7-9 am  9-11 am  11 am-1 pm  
 1-3 pm  3-5 pm  Anytime
28. Would you like to participate in our asthma educational program? Yes  No  Don't know
- This is a free benefit that is offered by Community Health Plan.  
No classes or travel are required.*
29. Is there anything else we can do to help you?

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