THE ASTHMA CENTER
COASTAL ALLERGY & ASTHMA, P.C.

ASTHMA CHECK-UP QUESTIONNAIRE

Patient Name: _____

DOB: _____MR#_____

Phone# _____

Email:_____

Goals for Asthma Control

What is your quick-relief/rescue medication for asthma?

_____

What is/are your daily asthma controller medication(s)?

_____

Last Xolair Injection _____?
(if applicable)

Your typical asthma symptoms
(check all that apply):

- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Chest Pain
- ☐ Other:_____

Timing of Symptoms (check all that apply):

- ☐ Randomly throughout the day
- ☐ In the early a.m.
- ☐ In the early p.m.
- ☐ In the middle of the night
- ☐ Interferes with sleep
- ☐ 24 hours a day
- ☐ During exercise
- ☐ Following exercise
- ☐ Associated with change in air temperature
- ☐ Associated with laughter
- ☐ When upset
- ☐ Following exposure to:_____

Chronic asthma control (last 12 months):

Number of asthma attacks a year _____
Number of days missed from activities a year due to asthma _____
Number of refills/yr of rescue medication _____
Number of ER visits/hospitalizations _____
Number of School/work days missed _____

Recent asthma control (last four weeks):

Do you use your rescue inhaler more than 2x/week?
Yes or No

Are you awakened at night with coughing or wheezing more than 2x/month?
Yes or No

Limited in performing usual activities? Yes or No

Do you use an Asthma Action Plan?
Yes or No

Peak Flow Personal Best _____

Home environment contains (check all that apply):

- ☐ Smokers
- ☐ Carpet in bedroom
- ☐ Down pillow/comforter on bed
- ☐ Visible mold
- ☐ Dog exposure
- ☐ Cat exposure
- ☐ Other pet exposure: _____
- ☐ Upper Respiratory Infection
- ☐ Sinus Infection
- ☐ Cold/Flu
- ☐ Pollen Exposure
- ☐ Chemical Exposure