

Adult Asthma Therapy Assessment Questionnaire

Please complete this questionnaire about your asthma.

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Has any doctor or medical provider ever told you that you have chronic bronchitis, emphysema, or Chronic Obstructive Pulmonary Disease (COPD)? | <input type="radio"/> | <input type="radio"/> |
| 2. Has any doctor or medical provider ever told you that you have asthma? | <input type="radio"/> | <input type="radio"/> |

(If no, please stop here and return the questionnaire)

If Yes, please continue to the next section.

- | | Yes | No | Unsure |
|---|-----------------------|-----------------------|-----------------------|
| 3. In the past four weeks, did you feel that your asthma was well controlled? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. In the past four weeks, did you miss any work, school or normal activity (i.e. household chores or social engagement) because of your asthma? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. In the past four weeks did your asthma wake you up at night? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. In the past twelve months, did you miss any work, school or normal activity (i.e. household chores or social engagement) because of your asthma? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. In the past twelve months, did your asthma wake you up at night? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. In the past twelve months, have you at any time taken medicine(s) for your asthma? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

(If no, please stop here and return the questionnaire)

- | | | | |
|--|-----------------------|-----------------------|-----------------------|
| 9. In the past twelve months, has your doctor or medical provider gone over with you how to take your asthma medicine(s)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Are you dissatisfied with any part of your current asthma treatment? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Do you believe you are able to take your asthma medicine(s) as directed? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Do you believe your medicine(s) is useful in controlling your asthma? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Do you and your doctor or medical provider make decisions together about your asthma treatment? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. Does your doctor or medical provider know how you prefer to take your asthma medicine(s) [such as by pill or inhaler once a day or more than once a day]? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. Do you have a written treatment plan from your doctor or medical provider on what to do if you have an asthma attack? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. Do you have a written treatment plan from your doctor or medical provider on how to take your asthma medicine(s) on days when you are NOT having an asthma attack? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

17. Do you use an inhaler for quick relief from asthma symptoms? Yes No Unsure

If you answered Yes to #17:

17 a. In the past four weeks, what was the highest number of puffs a day you took of this inhaler?
no puffs 1 to 4 puffs 5 to 8 puffs 9 to 12 puffs more than 12 puffs

17 b. In the past twelve months, on days you use an inhaler for quick relief, how many puffs a day do you usually take?
no puffs 1 to 4 puffs 5 to 8 puffs 9 to 12 puffs more than 12 puffs

18. Has your doctor or medical provider ever prescribed an asthma inhaler or pill that is NOT used for quick relief, but is used to control our asthma? Yes No Unsure

If you answered Yes to #18:

What best described how you take this medicine?

Take every day
Take some days
Used to take
Take when have symptoms
Never Took

19. What is your sex? Male Female

20. How old are you? 18-25 26-45 46-55 55-65 over 65

21. Thank you for completing this questionnaire! Is there anything yo would like to tell us about your asthma or the care you are receiving?
