# Pediatric Asthma Therapy Assessment Questionnaire

Please complete this questionnaire about your child's asthma.

1. What is your child's gender? ○ Male ○ Female
2. How old is your child? ○ 4 or younger ○ 5 to 10 ○ 11 to 14 ○ 15 or older
3. Has any doctor or medical provider ever told you that your child has asthma? ○ Yes ○ No

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

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4. For each season of the year, to what extent does your child usually have asthma symptoms? (Mark one box for each line)

| | A Lot | A Little | None |
|---|---|---|---|
| Winter | ○ | ○ | ○ |
| Spring | ○ | ○ | ○ |
| Summer | ○ | ○ | ○ |
| Fall | ○ | ○ | ○ |

5. In the past four weeks, how many days did your child…

| | None | 1 to 3 | 4 to 7 | Over 7 |
|---|---|---|---|---|
| a. Have wheezing or difficulty breathing when exercising? | ○ | ○ | ○ | ○ |
| b. Wake up at night with wheezing or difficult breathing? | ○ | ○ | ○ | ○ |
| c. Miss days of school because of his/her asthma? | ○ | ○ | ○ | ○ |
| d. Miss any activities (such as playing, going to a friend's house, or any family activity) because of his/her asthma? | ○ | ○ | ○ | ○ |

6. Are you dissatisfied with any part of your child's current asthma treatment?

| Yes | No | Unsure |
|---|---|---|
| ○ | ○ | ○ |

If you answered Yes to #6, Please Explain:

________________________________________

________________________________________

7. In the past twelve months, has your child at any time taken medicine(s) for his/her asthma?

| Yes | No |
|---|---|
| ○ | ○ |

8. Do yo believe…

| | Yes | No | Unsure |
|---|---|---|---|
| a. Your child's asthma was well controlled in the past four weeks? | ○ | ○ | ○ |
| b. Your child is able to administer his/her asthma medicine(s) as directed? | ○ | ○ | ○ |
| c. You have access to enough information to help your child control his/her asthma? | ○ | ○ | ○ |
| d. The medicine(s) your child takes are useful for controlling his/her asthma? | ○ | ○ | ○ |

| | | Yes | No | Unsure |
|---|---|---|---|---|
| 9. | Does your child's doctor or medical provider… | | | |
| | a. Involve you and your child in making decisions about your child's asthma treatment? | O | O | O |
| | b. Know how your child prefers to take his/her asthma medicine(s) (such as by chewable tablet, liquid r inhaler)? | O | O | O |
| 10. | In the past twelve months, has your child's doctor or medical provider gone over with you or your child how to take his/her asthma medicine(s)? | O | O | O |
| 11. | Do you and your chid have written instructions from his/her doctor or medical provider… | | | |
| | a. On what to do if he/she is having an asthma attack? | O | O | O |
| | b. On how to take his/her asthma medicine(s) on days when he/she is not having an asthma attack? | O | O | O |
| 12. | Does your child use an inhaler or nebulizer for quick relief from asthma symptoms? | O | O | O |

If you answered Yes to #12:

In the past four weeks, what was the highest number of times in one day your child used this inhaler/nebulizer?

O zero　O 1 to 2　O 3 to 4　O 5 to 6　O over 6

In the past twelve months, on days your child used an inhaler/nebulizer for quick relief, how many times a day did he/she usually use it?

O zero　O 1 to 2　O 3 to 4　O 5 to 6　O over 6

| | | Yes | No | Unsure |
|---|---|---|---|---|
| 13. | Has your child ever has a prescription for asthma medicine that is NOT used for quick relief, but is used to control their asthma? | O | O | O |

If you answered Yes to #13: What best describes how your child takes his medicine now?

(check one)

- O Takes it every day
- O Takes it some days, but not others
- O Used to take it, but now does not
- O Only takes it when having symptoms
- O Never took it

14. Thank you for completing this questionnaire! Is there anything you would like to tell us about your child's asthma or the care he/she is receiving?

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