CQN4 Asthma Data Collection Form

First Name: _____Last Name: _____Date of Birth: ____/___/_____ MRN: _____

Email address: _____ Insurance Company: _____

Date of Visit: ____/____/_____ Attending Physician: _____ Patient's first encounter form? ☐Yes ☐ No

Reason for visit: ☐Asthma well visit ☐ Asthma exacerbation ☐Asthma exacerbation follow up ☐Spirometry visit ☐Other

PARENT SECTION – Please complete questions 1-13. Thank you for helping us care for your child.

1. Has your child missed any days of school/daycare due to asthma in the past 6 months? ☐Yes ☐No ☐ Does not attend
   If yes, **enter the number of days of school/daycare your child has missed** in the past 6 months due to asthma ____ # of days
2. Have you or your spouse missed any work days due to your child's asthma in the past 6 months? ☐Yes ☐No ☐ Not currently employed
   If yes, **enter the number of days of work you or your spouse have missed** in the past 6 months due to your child's asthma ____ # of days
3. Has your child visited an Emergency Room or Urgent Care Center **due to asthma** in the **past 12 months?** ☐ Yes ☐No **If yes, how many visits?** ____
4. Has your child been admitted to the hospital **due to asthma** in the **past 12 months?** ☐Yes ☐No **If yes, how many admissions?** _____
5. During the **past week**, how often did your child need a fast acting or quick relief medication, at times **other than before exercise**? (includes Albuterol, Ventolin®, Proventil®, Xopenex®) ☐Not at all ☐Less than 1 time per day ☐ 1-3 times per day ☐ 4 or more times per day ☐ Not sure
6. For patients who use rescue/controller inhalers, is a spacer utilized? ☐Yes ☐ No ☐Not Sure
7. How often does asthma limit your child's activities? ☐Not at all ☐A little of the time ☐Some of the time ☐Most of the time ☐All of the time
8. Over the previous 2 to 4 weeks, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or reduced activity **due to asthma** *during the DAY?* ☐ 2 or fewer days per week ☐ more than 2 days per week but not daily ☐Daily ☐Throughout the day
9. Over the previous 2 to 4 weeks, how frequently has your child experienced episodes of cough, shortness of breath, wheezing or waking up **due to asthma** at *NIGHT*? ☐ 2 or fewer times per month ☐ 3-4 times per month ☐ More than 1 time per week but not nightly ☐Often 7 times per week
10. How would you rate your child's asthma control during the **past month**? ☐Very poorly controlled ☐Not well controlled ☐ Well controlled
11. How comfortable are you in your ability to manage your child's asthma, rated on a scale of 1-10? (Please circle)

    Not Comfortable = 1 2 3 4 5 6 7 8 9 10 = Very Comfortable
12. **Please mark all things (triggers) that make your child's asthma worse:**

☐Respiratory Infections ☐Heat/Humidity ☐ Changes in weather ☐Cold Air ☐ Air conditioning/Heating ☐Strong cleaners, air fresheners, aerosols, VOC's
☐Exercise/Increased Activity ☐Irritants (select all that apply ☐Tobacco Smoke ☐Wood Smoke ☐Air Pollution ☐Perfumes ☐Incense)
☐Allergens (select all that apply ☐Carpeting ☐ Cockroaches ☐Rodents ☐ Animals ☐ Dust ☐ Pollen ☐ Stuffed Animals ☐ Clutter ☐ Food ☐ Mold)
☐Other: _____ ☐ Don't know ☐None

13. When are **asthma** symptoms worse? (**Check all** that apply) ☐Winter ☐Spring ☐ Summer ☐Fall

PHYSICIAN SECTION

14. Has the patient received oral steroids for bronchospasm within the **past 12 months?** ☐Yes ☐No
15. Indicate the patient's asthma severity level: (refer to the EPR-3 Tables 4-2a, 4-2b, and 4-6.)
    ☐Severe Persistent ☐ Moderate Persistent ☐Mild Persistent ☐Intermittent
16. Physician assessment of control: What is the patient's current level of control during the past month?* (**refer to the NHLBI EPR-3 control tables** - 3-5a, 3-5b, 3-5c, 4-3a, 4-3b, 4-7) ☐Well controlled ☐Not well controlled ☐Very poorly controlled
17. Have you used the age-appropriate NHLBI EPR-3 stepwise table to identify treatment options or to adjust therapy based on asthma control? (refer to the Stepwise Tables 4-1a, 4-1b, 4-5) ☐Yes ☐No
18a. Is the patient on a controller medication? ☐Yes ☐No Medication name: _____
18b. If Yes, does the patient/parent report using controller medications daily? ☐Yes ☐No ☐Started this visit
19a. Does the patient have a written asthma action plan? ☐Yes ☐No
19b. If yes, was the plan updated as needed and reviewed with the patient and/or family at this visit? ☐Yes ☐No
20. For patients age 5 years and older, has the patient had spirometry in the past 1-2 years? (**Refer to Box** 3-2)
    ☐Yes: date____/____/____ ☐No ☐N/A –Younger than 5 years
21. Were asthma patient/family educational materials (other than the asthma action plan) provided and explained at this visit? ☐Yes ☐No
    ☐ Medication education ☐Environmental triggers ☐ Smoking cessation ☐ Flu shot info ☐ Allergy testing ☐Use of a spacer ☐ Other: _____
22a. **September-March (active flu season):** Was a flu shot received? ☐Yes date____/____/____ ☐No (see below)
    If no, reason ☐Patient younger than 6 months ☐ Other contraindications ☐ Vaccine unavailable ☐ Other, please specify: _____
22b. **April-August (not flu season):** Was a flu shot recommendation made for upcoming flu season? ☐Yes ☐No (see below)
    If no, reason ☐ Patient younger than 6 months ☐ Other contraindications
23. Has the patient been seen by an allergist or pulmonologist during the **last 12 months** for assistance with asthma management due to severity of illness?
    (refer to specialist referral criteria) Specialist: _____ ☐Yes ☐No ☐Referred this visit
24. Asthma Follow-up Visit: Return in: _____ weeks, or _____ months