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104.49

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101.1

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104.50

Patient ID |__|__|__|__|__|__|__|__|__|

Physician ID |__|__|__|__|__|__|

Clinic/Site ID |__|__|__|__|__|__|__|__|

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Patient Questionnaire

ASTHMA FORM 10.1

TO BE COMPLETED BY PATIENT

Original by Robert Bethel, M.D.
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INSTRUCTIONS:
This survey asks for your views about your asthma symptoms. This information will be summarized in your medical record and will help your doctors keep track of how you feel and how well you are able to do your usual activities.

Answer each question by circling the appropriate number, or filling in the boxes and spaces. If you are unsure about how to answer a question, please give the best answer you can.

1. How old were you when your asthma began? 1.260

   Age (fill in boxes) .... ☐☐ years old

2. How many times have you ever been hospitalized for asthma? (check one box) 1.261

   - Never .... ☐
   - 1 time .... ☐
   - 2 times .... ☐
   - 3–4 times .... ☐
   - 5 or more times .... ☐

3. When was the last time you were hospitalized for asthma? (check one box) 104.54

   - Within the last week .... ☐
   - Within the last month .... ☐
   - Within the last 6 months .... ☐
   - Within the last 12 months .... ☐
   - More than 12 months ago .... ☐
   - Never .... ☐

4. When was the **last time** you had a severe flare-up of asthma that needed urgent treatment? (check one box) 104.54

   - Within the last week .... ☐
   - Within the last month .... ☐
   - Within the last 6 months .... ☐
   - Within the last 12 months .... ☐
   - More than 12 months ago .... ☐
   - Never .... ☐

5. Over the last 12 months, how many times have you gone for care to a: 104.56

   a. Hospital emergency room **for your asthma?** ___________
      (if you did not go to an emergency room for your asthma in the last 12 months, enter zero)

   b. Urgent care center **for your asthma?** ___________
      (if you did not go to an urgent care center for your asthma in the last 12 months, enter zero)

   c. Urgent same day office visit **for your asthma?** ___________
      (if you did not have an urgent same day office visit for your asthma in the last 12 months, enter zero)

6. During the **past 4 weeks** how often have you awakened with asthma symptoms? (check one box)

104.57

- Never ☐
- Less than once a week ☐
- One to two nights a week ☐
- Three to seven nights a week ☐
- Usually more than once a night ☐

7. During the **past 4 weeks**, how much did **your asthma** cause difficulty for you doing daily work, participating in social activities, both inside and outside the house, or at school? (check one box)

104.58

- Not at all ☐
- A little bit ☐
- Moderately ☐
- Quite a bit ☐
- Could not do daily work ☐

8. During the **past 4 weeks**, how much time have you missed from work, school, or your usual activities because of **your asthma**? (check one box)

104.59

- None ☐
- One day to three days ☐
- Four days to seven days ☐
- Eight days to fourteen days ☐
- Fifteen days to twenty-one days ☐
- Twenty-two days to twenty-eight days ☐

9. Over the **past 4 weeks**, how often have you had the following symptoms? (check one box in each row)

104.60	Never	Occasionally	Every day	Many times a day	All the time
a. Cough	☐	☐	☐	☐	☐
b. Sputum (phlegm when coughing)	☐	☐	☐	☐	☐
c. Chest tightness (difficulty exhaling)	☐	☐	☐	☐	☐
d. Wheezy or whistling sound in the chest	☐	☐	☐	☐	☐
e. Shortness of breath	☐	☐	☐	☐	☐
f. Indigestion (heartburn)	☐	☐	☐	☐	☐
g. Hands that tremble	☐	☐	☐	☐	☐
h. Heart palpitations	☐	☐	☐	☐	☐
i. Difficulty with exercise	☐	☐	☐	☐	☐
j. Sinus infections	☐	☐	☐	☐	☐

10. Do you receive regularly scheduled allergy shots (at least once every other month) to decrease your asthma? (check one box)

1.272

- Yes ☐
- No ☐

11. Is your physical activity limited by any condition other than asthma? (check one box)

Yes .... ☐ 100.383
No .... ☐

The next few questions are about medications.

12a. During the **past 6 months**, have you taken prednisone, Medrol, or another steroid pill/cortisone to control your asthma? (check one box)

Yes (continue) .... ☐ 104.61
No (skip to question 13a) .... ☐
Don't know (skip to question 13a)................................. ☐

b. Do you take steroids regularly or only for a specific period of time (7–10 days)? 104.62

Regularly (skip to question 13a) .... ☐
Short period of time (continue) .... ☐

c. How many times in the last six months have you taken a short course of steroids? 104.63

Once .... ☐
Twice .... ☐
Three or more times .... ☐

13a. Do you take any other pills or liquids for your asthma? (check one box) 100.1448

Yes (continue) .... ☐
No (skip to question 14) .... ☐
Don't know (skip to question 14)..................................... ☐

13b. Which of the following pills or liquids do you take regularly? (check one box in each row) 100.64

	Use	Don't use	Don't know
Slo-phyllin, Theo-24, Quibron, Slo-bids, Theodur, Uniphyl, Unidur, or other theophylline or Aminophylline	☐	☐	☐
Brethine, Bricanyl, Proventil, Ventolin, Alupent, Metaprel, terbutaline, albuterol, or Volmax	☐	☐	☐
Zilueton	☐	☐	☐
Other (please list)	☐	☐	☐

____

14. Do you use any inhalers for your asthma? (check one box)

Yes (continue) .... ☐ 104.65
No (skip to question 18) .... ☐
Don't know (skip to question 18)..................................... ☐

15. What is the average number of puffs per day that you use for the following inhalers (check one box in each row). (Please answer the following based on the <u>number of puffs</u> per day, **<u>even</u>** if it is different than what your doctor has prescribed.)

	Don't use	1–2/day	3–8/day	9–15/day	16 or more/day
15a. Alupent, Proventil, Ventolin, Tornalate, Brethair, Maxair, Bronkometer, Metaprel	☐	☐	☐	☐	☐
15b. Primatene, Bronkaid	☐	☐	☐	☐	☐
15c. Atrovent	☐	☐	☐	☐	☐
15d. Serevent	☐	☐	☐	☐	☐
15e. Intal, (Cromolyn), Nedocromil, (Tilade)	☐	☐	☐	☐	☐
15f. Azmacort, Vanceril, Beclovent Aerobid, or other inhaled steroid	☐	☐	☐	☐	☐
15g. Other (please list) ______________________	☐	☐	☐	☐	☐

15h. If you use any medication listed in **<u>Question 15a</u>** above, do you use it on an as needed basis (e.g. prn)?

- Yes ☐
- No ☐
- Not applicable ☐

15i. If you use any medication listed in **<u>Question15e or 15f</u>** above, are you supposed to take it every day?

- Yes (continue) ☐
- No (skip to question 17) ☐
- Not applicable (skip to question 17) ☐
- Don't know (skip to question 17) ☐

15j. How consistently do you take it? (check one box)

- Some of the time ☐
- Half of the time ☐
- Most of the time ☐
- All of the time ☐

16. Do you <u>not</u> take your medication sometimes because: (please answer **<u>Yes</u>** or **<u>No</u>** for each question by checking the appropriate box on each line)

	Yes	No
a. It does not help	☐	☐
b. Of its side effects, such as bad taste	☐	☐
c. Of inconvenience	☐	☐
d. It costs too much	☐	☐
e. You're worried about becoming dependent on medication	☐	☐

104.67

17. Do you use an extender or spacer with your inhalers? (check one box) — 104.68

Yes ☐
No ☐
Don't know ☐

18. **As a result of taking any of your asthma medicines**, how often do you experience the following? (check one box in each row) — 104.69

	Never	Occasionally	All the time
a. Bad taste	☐	☐	☐
b. Difficulty sleeping	☐	☐	☐
c. Shakiness (tremors)	☐	☐	☐
d. Heart palpitations (skipped or extra beats)	☐	☐	☐
e. Headaches	☐	☐	☐
f. Nervousness, moodiness, irritability	☐	☐	☐
g. Hoarseness	☐	☐	☐
h. Thrush or yeast infections	☐	☐	☐

19a. Do you have a peak flow meter? (check one box) — 104.70

Yes (continue) ☐
No (skip to Question 20a) ☐

19b. When do you use your peak flow meter? (check one box) — 104.71

Never (skip to Question 20a) ☐
Daily ☐
As needed ☐

19c. What do you do with your peak flow meter results? (check all that apply) — 104.72

Adjust my medications ☐
Alter my activities ☐
Notify my physician ☐
Other ☐

20a. Have you ever smoked cigarettes regularly? (check one box) — 104.437.1-104.437.3

Yes (continue) ☐
No (skip to Question 21) ☐

20b. If yes, do you smoke now? (circle one response)

NO: How many years has it been since you smoked cigarettes regularly? __________

YES: On average, about how many cigarettes a day do you smoke? __________

21. How much information have you been given by your doctor or nurse about the following: (check one box in each row)

	Nothing	Some information	Everything I need to know
a. What to do when you have a severe flare-up of your asthma?	☐	☐	☐
b. How to adjust your medication when your asthma gets worse?	☐	☐	☐
c. What things can make your asthma worse and how to avoid them?	☐	☐	☐

22. How would you rate your knowledge about what to do if you had a severe asthma attack? (check one)

104.438

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

23. Do things like cats, dogs, or other pets, house dust, pollens, aspirin, or certain food additives such as sulfites make your asthma worse? (check one box)

104.439

- Yes ☐
- No ☐