

Asthma Checklist

Asthma Questionnaire

Name: _____

ID Number: _____

This questionnaire is designed to be used by nurses at the time of physician visit to gather pertinent information about the patient's asthma management and quickly assess the patient's condition.

Peak Flow: Personal Best _____

Warning _____

Alert _____

1. Action/Crisis Plan

Do you have an action/crisis plan?

Yes

No

If yes, describe plan:

2. Activity Level

What is your activity level? _____

3. Wheezing

Have you experienced wheezing?

Yes

No

4. Awakenings

Are you awakened from sleep because of asthma?

Yes

No

5. Work/School Absence

Have you missed any school or work because of asthma?

Yes

No

If yes, indicate the number of days missed in the past year: _____

6. Medical Devices

Do you use any medical devices such as spacers or nebulizers to take medication?

Yes

No

7. Inhaler Technique

Describe the inhaler you use as well as the technique utilized:

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8. Education Classes

Have you been given adequate information on managing your asthma?

Yes

No

9. Environmental Control

Have you modified your home and/or work environment to reduce triggers?

Yes

No

10. Peak Flow Monitor

Do you perform peak flow monitoring?

Yes

No

11. Personal Concerns

Do you have any personal concerns or fears regarding asthma?

Yes

No

12. Medications

What is your daily medication regimen?

13. Medication Usage

How many times per day do you use your quick-relief medicine (bronchodilator)? _____

How many puffs do you inhale per use? _____

14. Asthma Control

In your opinion, how well controlled is your asthma?

Very Good

Good

Moderate

Poor

Very Poor

15. Satisfaction

How satisfied are you with your asthma care?

Very Satisfied

Somewhat Satisfied

Neutral

Not Satisfied

Totally Dissatisfied

Asthma Checklist

Office Flowsheet

Name: _____

ID Number: _____

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Age

Predicted Flow Rates – FEV₁ _____

FVC _____

Peak Flow (PEF) _____

Date/Time						
Physician						
Height/Weight						
Pulse/Resp.						
Temperature						
Blood Pressure						
FEV ₁ actual/predicted						
FVC actual/predicted						
Peak Flow (PEF) actual/predicted						

List patient's medications and update as needed:

	Start Date	Stop Date		Start Date	Stop Date
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		