Mumford ISD: Asthma Symptom Questionnaire

Student Name: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

Name of Doctor treating asthma: _____ Phone: _____

Hospital preference (in case of emergency)_____

1. At what age was your child's asthma diagnosed? _____

2. In your opinion, how severe is your child's asthma? (circle one): Mild / Moderate / Severe

3. What are your child's usual signs/symptoms during an asthma attack? (check all that apply)
   ◯ Wheezing ◯ Cough ◯ Difficulty Breathing ◯ Chest Tightness
   ◯ Anxiety ◯ Other_____

4. How many days of school would you estimate your child missed last year due to asthma? _____

5. In the past 12 months, how many times has your child:
   A) been to the emergency room for asthma symptoms? _____
   B) been hospitalized for asthma symptoms?_____

6. How often do asthma symptoms occur? (circle one) Rarely / Seasonally / Monthly / Weekly / Daily

7. What triggers your child's asthma symptoms? (check all that apply)
   ◯ Exercise ◯ Stress ◯ Cold air ◯ Illness ◯ Smoke ◯ Allergies:_____

8. What does your child do at home to relieve the symptoms during an attack? (check all that apply)
   ◯ Rest ◯ Drinks fluids ◯ Breathing exercises ◯ Medication ◯ Other_____

9. Does your child have an Asthma Action Plan-a written treatment plan by a physician? *Yes / No
   *If yes, please provide a copy of the action plan with this questionnaire.

10. What medications are being using presently to control or treat asthma symptoms?

Name of Medication	Dose	How often

11. Does your child know when medication is needed? Yes / No
12. If your child uses an inhaler, is a spacer used? Yes / No
13. Does your child need medication at school? Yes / No
14. Has your child had asthma education? Yes / No
15. Does anyone smoke in the home? Yes / No

Additional information regarding your child's asthma:

_____

_____

Parent/Guardian Signature_____ Date_____