Form #1: Pediatric Information Form

ASTHMA BOTHER

QUESTION	PROBE	NOTES
• How much does asthma get in the way of what you need and want to do every day?	❑ Activity level (Sports, Playing with friends) ❑ School and/or home life ❑ Relationships with friends/family ❑ How you see yourself ❑ Anything else?	
• Of the things you just mentioned, what bothers you the most or what would you most like to change? • Parent, what concerns you most?		
• How old were you when you were diagnosed with asthma?		• Years ______

SYMPTOMS

QUESTION	PROBE	NOTES
• In the past month, did your asthma wake you up at night (including asthma-related coughing)?	• [If yes] How often?	• Awakened at night? ❑ Y ❑ N • Frequency or # of times? ______
• In the past month, did you miss any normal activities because of your asthma? (school, sports, extracurriculars, etc.)	• [If yes] How often?	• Missed daily activity? ❑ Y ❑ N • Frequency or # of times? ______
• How often do you have episodes in which your asthma is especially bad (we call these asthma exacerbations, attacks, or flares)?		
• Have you ever had to go to the ER or an urgent care during an asthma attack?	• [If yes] When was the last time?	
• Have you been ever been in the hospital because of your asthma?	• [If yes] When was the last time? • Have you ever been intubated (had a breathing tube inserted)?	
• Does your asthma make you cough?	• [If yes] How often? • What is the cough like?	
• We cannot cure asthma, but we can control your symptoms with the right medications (decrease coughing, wheezing, etc.) [To child] How well-controlled do you think your asthma symptoms are? Parent, how well-controlled do you think his/her asthma is? • Can you two agree on how well-controlled your asthma is?		

Form completed by: ______

Date: ______

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CHRONIC RHINOSINUSITIS:

- Do you have a stuffy, runny, or plugged nose for a lot of the year? Y ❑ N ❑
- Do you have itchy, watery eyes a lot? Y ❑ N ❑
- Do you have drainage in the back of your throat (post-nasal drip) most of the year? Y ❑ N ❑
- Has your health care provider told you that you have chronic sinus problems or allergies? Y ❑ N ❑
- When you have a cold, do your nasal symptoms (stuffy or runny nose) usually last for 3 months or more? Y ❑ N ❑
- Do you have trouble smelling things? Y ❑ N ❑

Y ______

GERD:

- Do you have a burning feeling in your throat sometimes after you eat (heartburn or indigestion)? Y ❑ N ❑
- Does food sometimes come up in the back of your throat (regurgitation)? Y ❑ N ❑
- In the past month, have you had coughing, wheezing, or shortness of breath that was not relieved by taking your rescue medication ? Y ❑ N ❑

Y ______

MEDICATION USE: SHOW ASTHMA CONTROLLERS/RELIEVERS POSTERS

What are your CURRENT PRESCRIPTIONS for asthma? (Have parent assist if necessary.) Let's start with albuterol.

For each medication:

- ❑ How many puffs/pills are you supposed to take each time?
- ❑ How often is it supposed to be taken?
- ❑ How many days did you take it last week?
- ❑ How many puffs/pills do you usually take?
- ❑ How do you and/or your parent think this medication works for your asthma?

Show me how you use your inhaler?

[Examine technique using appropriate "Skills Checklist" on the last page. Note errors, but do no correct. Provider will review in detail and give patient handouts.]

❑ **Med 1** ALBUTEROL Rx: ______________

days taken last week __________
Usual # of puffs _________
How child and/or parent thinks it works:____________
____

❑ **Med 2** ______________ Rx: ______________

days taken last week __________
Usual # of puffs _________
How child and/or parent thinks it works:____________
____

❑ **Med 3** ______________ Rx: ______________

days taken last week __________
Usual # of puffs _________
How child and/or parent thinks it works:____________
____

❑ **Med 4** ______________ Rx: ______________

days taken last week __________
Usual # of puffs _________
How child and/or parent thinks it works:____________
____

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QUESTION	PROBE	NOTES
• Many people have a hard time taking their controller medication like their doctor told them to. [Point out what their controller medication is.] • How often do you miss taking a dose of your controller medication(s)? [State name(s)]	• What makes you not take your medicine? [Examples: forgetting, being too tired or busy, deciding not to]	
• Many people cut back on the amount of controller medication they take, or they don't take it as often or in the amount their doctor prescribes. • Have you or your parent decreased the amount of medicine you take? Why?	• What happened? • Did you continue taking a decreased amount or stop altogether? • How did that work out?	
• Have you tried taking more of your controller medications than what your doctor told you to take?	• What led you to do this? • What happened when you did it?	
• What asthma medicines have you tried in the past that you didn't think helped or had side effects?	• What happened when you took them? [Probe if reported problems are unlikely to be attributed to the medication] • What did you do about that? • Did any other asthma medications give you problems?	
• How do/would you feel about taking asthma controller medication every day? Parent, how do you feel about your child taking a controller medication every day?	• Are there any other things that might bother you about taking asthma medications every day?	
• What are the worst things about taking asthma medications every day? • Do you think that taking controller medications every day would make your asthma better?	• [If no] Why not?	
• Are you concerned about side effects of any asthma medications?	• What are you concerned about? [Probe further if side effects mentioned have not been documented]	

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ALTERNATIVE TREATMENTS

QUESTION	PROBE	NOTES
• Have you ever tried anything other than prescription medications to help with your asthma? For example: ❑ Vitamins ❑ Herbs ❑ Acupuncture ❑ Deep breathing yoga ❑ Seeing a chiropractor ❑ Anything else? • Did you add this/these treatments to your asthma medicines or did you try to use them instead of taking asthma medicine?	• [For each] Did it help your asthma? • Do you think any of these things were helpful in reducing your asthma symptoms? • [If no] Do you have any thoughts on why this didn't work for you?	

ENVIRONMENTAL TRIGGERS

QUESTION	PROBE	NOTES
• Are there different times of the year that your asthma is better or worse?	• When is it worse?	Worse at times? ❑ Y ❑ N When? ____________
• Are there certain things at home/school/ outside that make your asthma worse?	• [If yes] Can you give an example?	
• What changes have you and your family made at home to avoid your asthma symptoms? (Ex: Pillow Covers, Dehumidifier, No pets)	• Have those changes been helpful?	
• Are there more changes you think you and your parents could make?	• What are they? • What gets in the way of these	

- Does anyone at home smoke?
- [If yes] Have they tried to quit?
- In [middle or high] school, there is often peer pressure to begin smoking tobacco and marijuana. Smoking is bad for everyone, but it is especially bad for you because you have asthma. Smoking can make your asthma much worse and can lead to more asthma attacks and hospitalizations. I'm giving you some resources so you understand more about how hard it is to quit smoking and how bad it is for your asthma.

❑ Check box indicating that you have recommended cessation for smokers and provided handout resource "**Smoking and Asthma Don't Mix.**"

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