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| **C**ommunity **H**ealthcare for **A**sthma **M**anagement and **P**revention of **S**ymptoms | |
| Asthma Symptoms & Utilization: Baseline | |
| **Patient Name:** | **Date:** |

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| This form is used to collect information about the patient’s asthma at the beginning of the intervention. The answers on this form will be compared to the answers at 6 months and 12 months to chart patient improvement.  When asking the questions below, it is helpful to show the family a calendar as a reference. | |
| **1. In the last 4 weeks, how many days did the child have wheezing or tightness in the chest or cough?** | **2. In the last 4 weeks, how many days did the child have to slow down or stop play or activities because of asthma, wheezing or tightness in the chest, or cough?** |
| \_\_\_\_\_\_\_\_\_\_ days | \_\_\_\_\_\_\_\_\_\_ days |
| **3. In the last 4 weeks, how many nights did the child wake up because of asthma, wheezing or tightness in the chest, or cough?** | **4. During the last 4 weeks, how many days did the child miss school due to asthma?** |
| \_\_\_\_\_\_\_\_\_\_ nights | \_\_\_\_\_\_\_\_\_\_ days |
| **5. During the past 12 months, how many times did the patient have to stay overnight in the hospital for asthma problems or for any reason where asthma problems were addressed?** [Do not include overnight waits in the ED unless the child was there for more than 24 hours, not including the wait time. This should be the total number of admissions, not the total number of nights.] | **6. Not counting hospitalizations, during the past 12 months, how many times has the patient had an urgent visit to a clinic, doctor, or hospital emergency department for emergency care for asthma?** [By urgent visit, I mean not scheduled more than 1 day ahead of time. Do not include visits which resulted in an overnight hospitalization – hospitalizations are covered in question 5 – and do not count 2 visits to these types of facilities that occurred on the same day as separate events.] |
| \_\_\_\_\_\_\_\_\_\_ times | \_\_\_\_\_\_\_\_\_\_ times |
| **7. Is the child currently taking any medications prescribed for asthma every day, even when he is/she is well, to prevent symptoms?**  □ Yes  □ No | **8. Does the child have an Asthma Action Plan?** [An Asthma Action Plan is a set of written instructions that tell you how to take your medications when you are having asthma symptoms.]  □ Yes  □ No |