

## Your/Your Child's Asthma Visit – What to Expect, What to Ask

Your Name: \_\_\_\_\_  
Are there specific concerns you want to discuss today?

Your Relationship to the Child: \_\_\_\_\_  
 No  Yes \_\_\_\_\_

Have there been any major changes in your family lately?  
 None  Move  Job Change  Separation  Divorce  Death in the family  New pet  Other?  
Describe: \_\_\_\_\_

| <b>General Health Information. Since Your Last Visit:</b>   | <b>Yes</b>               | <b>No</b>                | <b>Unsure</b>            |
|---|--------------------------|--------------------------|--------------------------|
| Have you (or your child) had any major illness and/or hospitalizations?                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you or anyone in your family (or your child's relatives) developed new any medical problems?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any changes to your (or your child's) medications?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your (or your child's) immunizations (includes flu and pneumonia vaccines) current?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you or any adults who are around you (or your child) smoke (includes inside or outside the house)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Have you (or your child) been seen in the emergency room in the last 6 months for asthma?  
 No  Yes 1-2 times  Yes 3-4 times  Yes 5-6 times  Yes more than 6 times

Have you (or your child) been hospitalized for asthma in the last 12 months?  
 No  Yes 1-2 times  Yes 3-4 times  Yes 5-6 times  Yes more than 6 times

Do you (or your child) have any of the following asthma symptoms currently?  
 Coughing, especially at night  Wheezing  Shortness of breath  Chest tightness, pain, or pressure

Do you (or your child) have any early symptoms of an asthma attack?  
 Frequent cough, especially at night  Losing your breath easily or shortness of breath  Feeling very tired or weak when exercising  Wheezing or coughing after exercise

Do you (or your) child use a spacer?  
 No  No, do not have one  Yes, always  Yes, sometimes  Yes, seldom  Need to, do not have one

Do you (or your child) use a nebulizer?  
 No  No, do not have one  Yes, always  Yes, sometimes  Yes, seldom  Need to, do not have one

Do you (or your child) use a rescue inhaler?  
 No  No, do not have one  Yes, always  Yes, sometimes  Yes, seldom  Need to, do not have one

Ask your (or your child's) doctor about any specific concerns about asthma.

### Would you like to get more information on any of the topics below?

| <b>Medications/Treatments</b>   | <b>Symptoms</b>  | <b>Health Promotion</b>  | <b>Nutrition</b>   |
|---|--|--|--|
| <ul style="list-style-type: none"> <li>• Inhalers/rescue inhalers</li> <li>• Spacers</li> <li>• Nebulizers</li> <li>• Pulmonary Function Tests</li> <li>• Steroids</li> <li>• Asthma specialist</li> <li>• Herbal remedies</li> </ul> | <ul style="list-style-type: none"> <li>• Asthma triggers</li> <li>• Early symptoms of Asthma attack</li> <li>• Asthma symptoms</li> <li>• Depression</li> <li>• Other</li> </ul> | <ul style="list-style-type: none"> <li>• Smoking Cessation</li> <li>• Immunizations</li> <li>• Exercise routine</li> <li>• When to call doctor</li> <li>• Family Planning</li> <li>• Dental appointment</li> </ul> | <ul style="list-style-type: none"> <li>• Healthy diet</li> <li>• Healthy snacks</li> </ul> |

*This is not a self-diagnosis tool or a treatment plan. Please consult your doctor and share this with your doctor at your next visit.*