



Asthma Clinical Assessment Baseline



Household Address: _____ Zip Code _____

Child's DOB ____mm ____dd ____yy

Date of Call _____

HEALTH CARE UTILIZATION

Has your child been hospitalized for asthma in the past 3 months? Yes No
If Yes, how many times? _____

Has your child been admitted to the ER for asthma in the past 3 months? Yes No
If Yes, how many times? _____

Has your child been absent from school in the past 3 months? Yes No
If Yes, how many times? _____

Has your child used prednisone for asthma in the past 3 months? Yes No
If Yes, how many times? _____

RECENT EXPERIENCE OF ASTHMA SYMPTOMS

In the past TWO weeks, how often did ... your child have symptoms at night? < 2/week = 2/week Daily Weekly

... your child have symptoms during the day? < 2/week = 2/week Daily Weekly

...child's symptoms affect exercise or sports? Never Sometimes Always

USE OF ASTHMA MEDICATIONS

In the past TWO weeks how often has your child used rescue medications?
 ≤ 1 time/week = 2 times/week Daily

Does your child use a controller medication? Yes No
If YES, what is the name of the medication(s)

Does your child use their medications as prescribed? Yes No

How severe is your child's asthma? Mild Intermittent Mild Persistent Moderate Severe

Allergies: (circle all that apply) Cat, Dog, Dust, Mold, Cockroaches, Mice, Weeds, Trees, Grass, Peanuts, Milk, Stinging insects, Soy, Eggs, Tree nuts, Wheat, Other: _____

ASTHMA MANAGEMENT

Does your child have an asthma action plan? Yes No
Does your child use a peak flow meter? Yes No

Are there persons who smoke in the home? Outside? In the car?
 Parent Parent Parent
 Both parents Both parents Both parents
 Visitors Visitors Visitors
 Child Child Child

Are there pets in the home? Yes No
What kind? _____

ASTHMA SYMPTOMS AND QUALITY OF LIFE SURVEY

I have a few more questions to ask you. These questions are about your child's asthma symptoms.

When you think about the last **FOUR** weeks how often has:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Your child complained of being short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exertion (such as running) made your child breathless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child coughed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child been woken up by wheezing or coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child stayed indoors because of wheezing or coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child's education suffered due to his/her asthma (during school)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child's asthma interfered with his/her life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma limited your child's activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking his/her inhaler or other treatments interrupted your child's life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You had to made adjustments to family life because of your child's asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Services:

- Patient needs medical supplies (Physician needs to approve)
- Patient needs additional educational services (Physician needs to approve)
- Patient requires social service resources (Physician needs to approve)
- Patient needs to see physician
 - Directed mom/dad to call and make the appointment
 - PHS helped facilitate visit
- High Level intervention needed from SPPH (Physician needs to approve)
 - Landlord issues
 - Section-8 issues
- Health Call Referral (Physician needs to approve)
- Referred to Lead Program at SPPH
- Catholic Charity Voucher
- Recommended Moving
- Facilitated parent to refill medication
- Tenant to call code enforcement