PATIENT SELF-ASSESSMENT FORM – ASTHMA

Patient name: ___________________________________________________________ Date: ___________________________________________________________

Since your last visit:
1. Has your asthma been any worse? No _______ Yes _______
2. Have there been any changes in your home, work or school environment (such as a new pet or someone smoking)? No _______ Yes _______
3. Have you had any times when your symptoms were worse than usual? No _______ Yes _______
4. Has your asthma caused you to miss work or school or reduce or change your activities? No _______ Yes _______
5. Have you had any emergency room visits or hospital stays for asthma? No _______ Yes _______
6. Have you missed any regular doses of your medicines for any reason? No _______ Yes _______
7. Have your medications caused you any problems (shakiness, nervousness, bad taste, sore throat, upset stomach)? No _______ Yes _______
8. Please list the medications you currently take for asthma and how often you take each (more than once per day, once per day or less than once per day):
___________________________________________________________________________________________________________________________________
9. Do you need refills for any medication today? No _______ Yes _______

In the past two weeks:
10. Have you had a cough, wheezing, shortness of breath or chest tightness during:
the day? No _______ Yes _______
the night? No _______ Yes _______
exercise or play? No _______ Yes _______
11. Do you have a peak flow meter? No _______ Yes _______
   How often do you use it? _____ days per week
   What is your personal best? # _______ or Don’t know _______
12. How many days have you had to use your rescue inhaler? _____ days
13. Have you been satisfied with the way your asthma has been? No _______ Yes _______
14. What are some concerns or questions you would like to talk about during this visit?
___________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________

Provider’s signature: ________________________________________________________________________________________________________________