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?

    ____

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Provider's signature: ____