

# 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: \_\_\_\_\_



**FPM Toolbox** To find more practice resources, visit <https://www.aafp.org/fpm/toolbox>.

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