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: _____

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