Everett Public Schools
Health Services

Asthma Questionnaire

Student Name: _____ Date of Birth: _____
School: _____ School Year: _____
Student Number: _____ Grade: _____
Parent/Guardian: _____ Phone: _____
Health Care Provider: _____ Phone: _____Fax_____

1. How long has your child had asthma? _____

2. Please rate the severity of his/her asthma.(circle) (Not severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days would you estimate he/she missed school last year due to asthma? _____

4. What triggers your child's asthma attacks? (Please check any that apply).

   ☐ Illness ☐ Emotions ☐ Medications (name) _____
   ☐ Foods (List) _____
   ☐ Cigarette or other smoke ☐ Weather ☐ Exercise ☐ Fatigue
   ☐ Chemical odors (list) _____

   Please list all allergies: _____

5. What does your child do at home to relieve wheezing during an asthma attack? (Please check any that apply.)
   ☐ Breathing exercises ☐ Rest/relaxation ☐ Drinks liquids
   ☐ Takes medication: ☐ Inhaler ☐ Nebulizer ☐ Oral medication
   ☐ Other (Please describe) _____

6. Please list the medications your child takes for asthma (every day and as needed):

	Name of medication	**Dose**	**Frequency**
(In school)	_____	_____	_____
	_____	_____	_____
(At home)	_____	_____	_____
	_____	_____	_____

7. How many times has your child been hospitalized overnight or longer for asthma in the past year?
   _____

8. How many times has your child been treated in the emergency room for asthma in the past year?
   _____

9. How often does your child see his/her doctor for routine asthma evaluations? _____
   _____

Parent/guardian signature: _____ Date: _____