

Asthma Assessment

Name: _____

Date: _____ Visit #: _____

Previous ACT/C-ACT score: _____

| | | Yes | No | Notes |
|-----|---|-----|----|-------|
| 1. | Can you identify: <ul style="list-style-type: none"> Your early warning signs of asthma What to do when your asthma worsens | | | |
| 2. | Can you identify your asthma triggers? | | | |
| 3. | Ever tested or told by a healthcare provider that you have allergies? <ul style="list-style-type: none"> If yes, list known allergens and allergy medication(s) being taken Based on known allergens, is an air purifier recommended? | | | |
| 4. | Do you smoke? <ul style="list-style-type: none"> If yes, was smoking cessation education provided? | | | |
| 5. | Is breathing worse at night? | | | |
| 6. | Is your asthma worse during a specific season or a change in climate? | | | |
| 7. | Do you limit outdoor activities based on air quality alerts? | | | |
| 8. | In the past 12 months, have you received asthma services in the home? | | | |
| 9. | Do you know how to properly take your asthma medications? (i.e., which to take daily, which to take when asthma worsens) | | | |
| 10. | Do you have/can you locate an up-to-date Asthma Action Plan (AAP)? <ul style="list-style-type: none"> If no AAP, was one provided? If applicable, is a copy of the AAP on file with the school? | | | |
| 11. | (NYC only) If applicable, do you have an up-to-date Medication Administration Form on file with the school? | | | |
| 12. | Do you have a current prescription for quick relief/rescue medication? <ul style="list-style-type: none"> If yes, has the script been filled? If no, why not? If yes, how many of the past 7 days has the rescue medication been used? | | | 1-7: |
| 13. | Do you have a current prescription for a controller medication? <ul style="list-style-type: none"> If yes, has the script been filled? If no, why not? If yes, how many of the past 7 days has the controller been used? | | | 1-7: |
| 14. | Do you have a spacer/valved holding chamber for applicable medications? <ul style="list-style-type: none"> If yes, is it used every time? If no, spacer provided? | | | |
| 15. | If applicable, # of school/workdays missed due to asthma over the past 3 months for person with asthma | #: | | |
| 16. | If applicable, # of school/workdays missed due to asthma over the past 3 months for parent/caregiver | #: | | |
| 17. | Number of unscheduled visits in the past 12 months to doctor/urgent care for worsening asthma or an asthma attack | #: | | |
| 18. | Number of ED visits in the past 12 months for worsening asthma or an asthma attack | #: | | |