Asthma Pre-visit Worksheet (child) **Name:** **Date:**

This worksheet will help you get ready for your child's visit to talk to a doctor about their breathing problems.

How old was your child when they started having breathing problems? Age: _____ years

How old was your child when they were diagnosed with asthma? Age: _____ years No diagnosis ☐

Does/has your child ever (circle or check and add details):

Miss school for breathing issues? ☐ yes ☐ no # Days _____ per month/ year

Wake up at night coughing? ☐ yes ☐ no ☐ Every night OR # nights per month _____

Had coughing, noisy breathing or shortness of breath during the day? ☐ yes ☐ no ☐ Every day OR # days per week_____

If you hear noisy breathing, does it happen when your child breathes in? Or out? ☐ in ☐ out

Had to limit their activities? ☐ yes ☐ no

Gone to the Emergency Room for breathing issues? ☐ yes ☐ no # in past year_____ # lifetime_____

Been hospitalized for asthma or breathing issues? ☐ yes ☐ no # _____ past year/ lifetime_____

Been hospitalized in the ICU because of asthma? ☐ yes ☐ no # _____lifetime

Had to be intubated (tube down throat to help breathe)? ☐ yes ☐ no # times in lifetime_____

Taken oral steroids pills (prednisone) or shots in the past year? ☐ yes ☐ no #_____

Possible triggers- things that make your child's breathing worse:

Does anyone in the house smoke? ☐ yes ☐ no

Exposed to smoke outside the home? ☐ yes ☐ no

Have you noticed anything in your child's environment that makes their breathing worse? (circle or check all that apply)

☐ Smoke ☐ Pets ☐ Colds/respiratory infections ☐ Pollen ☐ Mold/mildew ☐ Cockroaches

☐ Emotions ☐ Stress ☐ Strong chemicals ☐ Dust ☐ Changes in weather ☐ NSAIDs

☐ Playing outside ☐ Pollution ☐ Breathing cold air ☐ Other:_____

☐ Exercise (type)_____ ☐ Other: _____

☐ Does your child have a history of eczema, hay fever or other allergies including foods? ☐ yes ☐ no

☐ Does anyone in your family have asthma or allergies? ☐ yes ☐ no

Which months are the worst for your child's breathing? (circle or check all that apply)

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

If your child has asthma:

Do you feel like your child's asthma has been well controlled? ☐ Yes ☐ No

Do you feel that you understand how the lungs work and how they are different in asthmatics? ☐ Yes ☐ No

Do you feel that you know what triggers to avoid so your child is less likely to have an asthma attack? ☐ Yes ☐ No

Do you feel like you give your child their medications correctly? ☐ Yes ☐ No

Do you ever miss any of your child's medication doses? If yes, how many days a week? _____ ☐ Yes ☐ No

Do you feel like you know what to do in the event of an asthma attack? ☐ Yes ☐ No

Does your child have a current asthma action plan? ☐ Yes ☐ No

What medication has your child taken in the past for breathing issues?

Medication Name	Medication Dose	How often taken	Why was it stopped?

What medications is your child currently taking for breathing issues?

Medication Name	Medication Dose	How often taken	Is this medicine a controller or reliever medicine? (circle or check)
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐

If your child has been taking inhalers (puffers), do they use a chamber/spacer? ☐ Yes ☐ No

What are your goals for your child and their asthma?

☐ Decrease the number of school days/work missed
☐ Sleep through the night
☐ Able to play sports or exercise
☐ Decrease the number of emergency room visits
☐ Able to play outside
☐ No hospitalizations
☐ Feel like my/my child's asthma is under control

Other:_____

Other: _____

Do you have anything else that you would like to talk to your doctor about?