# Asthma Questionnaire for Students

Student's Name_____ Grade____

Parent's Name_____

1. How old were you when you started having asthma? ___ _
2. How severe is your asthma?
   a. mild
   b. moderate
   c. severe
3. What are your usual signs/symptoms during as asthma attack?
   a. wheezing
   b. cough
   c. difficulty breathing
   d. chest tightness
   e. anxiety
   f. other_____
4. How many days of school would you estimate you have missed last year due to asthma?
5. In the past year, how many times have you been treated in the emergency room for asthma symptoms?
6. In the past year, how many times have you been hospitalized (overnight or longer) for asthma symptoms?
7. In the past month, during the day, how often have you had asthma symptoms?
8. In the past month, during the night, how often do you wake up or experience asthma symptoms?
9. What triggers your asthma symptoms?
   a. exercise
   b. stress
   c. cold
   d. air
   e. illness
   f. allergies to _____
   g. Smoke (Does anyone smoke at home?----------
   h. other _____

Please complete back side also!

I0. What do you do at home to relieve the symptoms during an attack?

a. Rests

b. drinks fluids

c. uses breathing exercises

d. checks peak flow

e. takes medication

f. other_____

! 11. Do you know how to use a peak flow meter? □ Yes ☐ No

12. What is your personal best peak flow reading? --------

13. What medications do you use presently to control or treat asthma symptoms?

| Name of Medication | What is Dose? | How often is it taken? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

14. Do you know when you need medication? D Yes ☐No

15. If you use an inhaler, do you use a spacer? ☐Yes DNo

16. Have you had asthma education? ☐Yes ☐No

17. Would you like more information about asthma? ☐Yes ☐No

Comments:

Student Signature_____ Date------