Figure 1

Child's Name: ______________________________ **Child's Date of Birth:** ____________________

PLEASE PRINT CLEARLY MONTH/DAY/YEAR

Easy Breathing Survey

The Vermont Asthma Program, part of the Vermont Department of Health, is working with to improve asthma care in children.
The Program requested a copy of this survey, the doctor's assessment, and if needed, a copy of your child's asthma treatment plan. This authorization to disclose health information has no expiration date and once disclosed, may no longer be protected under the Federal Privacy Rule. You may refuse to complete the survey without penalty. You may revoke your permission to use this information by writing to your doctor.

****PLEASE SIGN HERE if you agree to the above: ________________________________(Parent/Guardian Signature)**

1. **Has your child had wheezing or whistling in the chest at any time in the last 12 months?** Yes No
2. **Has your child awakened at night because of coughing in the last 12 months?** Yes No
3. **Has your child had coughing, wheezing, or shortness of breath with exercise or activity and had to stop because of these symptoms at any time in the last 12 months?** Yes No
4. **When your child has a cold, does the cough usually last more than 10 days?** Yes No
5. **Has anyone ever told you your child has asthma?** Yes No
   If yes, how many time has your child:
   A) <u>**In the past year,**</u> been hospitalized because of asthma? # of times: _________
   B) <u>**In the past year,**</u> been to the emergency department or had an acute office visit because of asthma? # of times: _________
   C) <u>**In his/her lifetime**</u>, ever been admitted to the intensive care unit because of asthma? # of times: _________
   If yes, ask for an Asthma Control Test™ to see if your asthma is in good control.
6. **Is your child taking any medications, pills, or inhalers (pumps, puffers) for asthma?** Yes No
7. **Has anyone told you your child has eczema?** Yes No
8. **Does anyone in your family have asthma?** If yes, who? (in relation to your child) Yes No
   For example: Child's aunt, child's mother, etc. __________ ____________ ___________ _____________
9. **What is your child's ethnic origin? (Circle only one)**
   Black/African American Asian or Pacific Islander White/Caucasian
   Hispanic or Latino American Indian/Alaska Native Other _______________
10. **What is your child's sex?** Male Female
11. **What is your child's insurance?** ☐ Medicaid /Green Mountain Care (Dr. Dynasaur) ☐ No insurance/Self-pay
    ☐ Private (MVP, BlueCross, Cigna, etc.) ☐ Other:________________________
12. **What town do you live in?** ______________________ **13. What is your address?** ____________________________
14. **Is your child exposed to the following *more than* 2 times/week?:**
    Cigarette or Cigar smoke Yes No ⟶ If **yes**, who smokes (mother, father, grandmother, etc.) _______________
    Pets Yes No ⟶ If **yes**, type of pet (Circle all) Dog Cat Bird Rodent Other
    Fireplace /Wood-burning heat source Yes No

*****Please do not write below this line. Official use only.**

Doctor, Does this child have asthma? **Yes**-Previously Diagnosed **Yes**– New Diagnosis **No** **Unable to Determine**

If this is a **new diagnosis**, obtain information below to aid in determining severity:

Frequency of episodes of cough, wheeze, shortness of breath (daytime)	≤2x/wk	>2x/wk <qd	Daily	Continuously
Frequency of nighttime symptoms	≤2x/mo	>2x/mo	>1x/wk	>4x/wk
Exercise impairment (even with pre-treatment with beta-agonist)	None	Occasionally	Some	Always
School absenteeism for asthma past year (days/month)	< 3	3-5	6-8	> 8
Asthma Severity is:	**Intermittent**	**Mild**	**Moderate**	**Severe**

If this patient has been **previously diagnosed** with asthma, either obtain information below to aid in determining asthma control or if >4 years of age have parent/patient complete the appropriate *Asthma Control Test™*.

Nocturnal Symptoms	None	< 1/week	≥ 1/week
Exercise tolerance	Good	Limited	Severely Limited
School/Work absenteeism (for asthma)	None	≤ 2/month	> 2/month
Use of PRN medications	None	≤1/week	>1/week
Use of prednisone (since last visit)	None		≥ 1
Current Asthma Control is: (Circle One)	**Good**	**Marginal**	**Inadequate**

Asthma Severity is: (Circle One) **1) Intermittent** **2) Mild Persistent** **3) Moderate Persistent** **4) Severe Persistent**

Is this child being seen by an asthma specialist? Yes No ****Assessor's Signature:** ____________________________**