PAK
PEDIATRIC ASSOCIATES OF KINGSTON
Taking Exceptional Care of the Next Generation since 1967

NEPA
BREASTFEEDING CENTER

Date: _____

Asthma Assessment Questionnaire

Patient Name:_____ DOB:_____

Circle all that apply

Does anyone in the family have a history of :

- Asthma
- Allergic Rhinitis (allergies)
- Tobacco use
- Cardiac disease
- Thyroid disorders

Do you experience any of these symptoms?

- Cough or lingering cough
- Recurrent wheezing
- Shortness of breath or difficulty breathing
- Recurrent chest tightness

When do your symptoms occur?

- Are they persistent or daily
- Are they intermittent
- Are they worse at particular times of the year
- Do they occur at night
- Do they wake you up at night or early in the morning
- Do they interfere with your normal activities

Does anything make your symptoms worse?

- Exercise
- Colds or viruses
- Allergy symptoms
- Animals or pets
- Weather changes (hot/humid/cold)
- Emotions (laughing/crying)
- Increased stress
- Menses
- Passive smoke
- Wood burning stove or Kerosene heater
- Aspirin/Ibuprofen/Motrin
- Blood pressure medication

(Continued on back)

Does the patient have a history of?

- Respiratory distress in the first month after birth
- Needing a tube to help them breath
- RSV or Bronchiolitis under the age of one year
- Asthma
- Exercise Induced Asthma
- Eczema or A-topic Dermatitis
- Sinus infections or recurrent colds
- Gastroesophageal Reflux Disease or GERD
- Allergic rhinitis or persistent post-nasal-drip
- Wheezing without illness
- Snoring or Obstructive Sleep Apnea
- Obesity
- Depression/Stress
- Cardiac disease
- Thyroid disease

Past Medical History for children under 5 years of age

- Does the patient experience recurrent wheezing?
- Is there a parental history of asthma?
- Does the patient have Eczema?
- Does the patient have allergies?
- Does the patient wheeze without illness