

Please fill out this form and give it to your doctor. Your answers will help us work with you to keep your asthma under control.

to	keep your asthma under control.						
1.	Overall, how is your asthma?  About the same as usual  It seems to be getting better  It seems to be getting worse						
2.	Sometimes asthma makes it hard to do things in everyday life. During the <i>past 4 weeks</i> , has asthma kept you from doing things or made you miss time at school or work?   yes  no						
3.	Sometimes people with asthma wake up at night from coughing and wheezing. During the <i>past 4 weeks</i> , has this happened to you?  yes no						
4.	During the <i>past 6 months</i> , have you gone to the emergency room or urgent care because of problems with asthma?  ———————————————————————————————————						
5.	Have you had to stay overnight in the hospital for your asthma any time during the <i>past 12 months</i> ?  ☐ yes ☐ no						
6.	Do you usually take medicine for asthma <b>every day</b> , even when you are not having any asthma problems?						
	☐ yes → Which kinds do you take? ☐ prescription medicine						
	no medicine I buy without a doctor's prescription						



Υοι	ur name	·			
Date		Medical record #			
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8.	how to	use y	, nurse, or our asthm		rmacist taught you alers?
9.	asthma	a medi			of your
10.	•				ma Action Plan? don't know
11.	-		a peak flo		neter? don't know
12.	-				more about any of mark the box:
		Ways	to help pr	reven	at asthma attacks
		Safet	y of taking	g asth	nma medicines
		the si		othe	co smoke (breathing er people's cigaret
		Gettii	ng help to	quit	smoking
			things yo g your vis		nt to talk about lay: