

ASTHMA SCREENING PROGRAM

Registration and Report Form

Date ____ / ____ / ____
MONTH DAY YEAR

PARTICIPANT: PLEASE COMPLETE THIS SECTION

If participant is a child, a parent should help complete Page 1 of the form and sign the release at the bottom of the page.

Name _____ Birth Date ____ / ____ / ____

Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ (Work) _____

Sex: Male _____ Female _____ **Age:** _____ **Height:** _____ **Weight:** _____

Are you? White _____ Black _____ Hispanic _____ Asian _____ Native Amer. _____ Other _____

Education Completed:

Elementary _____ High School _____ 2 years college _____ 4 years college _____ Graduate degree _____

Do you have allergies? Yes _____ No _____

If so, to what are you allergic? _____

Do you smoke? Yes _____ No _____

Have you ever been diagnosed as having asthma? Yes _____ No _____

If "yes" and you are currently receiving medical care for asthma, what kind of doctor is providing that care?

Pediatrician _____ Internist _____ Family Practice Physician _____

Allergist _____ Pulmonologist _____ Other _____ Not being treated _____

Have you ever been treated by an allergist? Yes _____ No _____ Don't know _____

RELEASE FORM

I hereby release the screening physician, all other health care volunteers and the sponsoring agencies of the Asthma Screening Program from all responsibility in connection with this screening examination. I understand that the examination results will be given to me with recommendations and that I am responsible for any costs involved in following those recommendations. I also understand that this is a rapid screening and is not a complete asthma examination. The screening is voluntary and free of charge. I understand that:

1. This screening examination is not as complete as, or a substitute for, a full asthma examination by my own physician.
2. The responsibility for any follow-up examinations to check abnormalities found during the Asthma Screening Program examination lies with me and not with any participating organization, physician or other health care volunteer. I am responsible for my own health.

3. No other individual or agency may use my individual examination results for any other purpose without my express written permission, except that information from my examination results may be used in a statistical study as long as my name is not published with any study or examination results.

I have read, understand and accept the above paragraphs.

Signature _____ Date _____

Signature of parent if participant is under 18.

Signature _____ Date _____

Questionnaire for Adults (Ages 15 and Over)

Name _____

Date ____ / ____ / ____

Please answer the following questions “yes” or “no”:

YES **NO**

- 1. When I walk or do simple chores, I have trouble breathing or I cough.
- 2. When I perform heavier work, such as walking up hills and stairs or doing chores that involve lifting, I have trouble breathing or I cough.
- 3. Sometimes I avoid exercising or taking part in sports like jogging, swimming, tennis or aerobics because I have trouble breathing or I cough.
- 4. I have been unable to sleep through the night without coughing attacks or shortness of breath.
- 5. Sometimes I can't catch a good, deep breath.
- 6. Sometimes I make wheezing sounds in my chest.
- 7. Sometimes my chest feels tight.
- 8. Sometimes I cough a lot.
- 9. Dust, pollen or pets make my breathing more difficult.
- 10. Cold weather makes my breathing more difficult.
- 11. My breathing problem gets worse when I'm around tobacco smoke, fumes or strong odors.
- 12. When I catch a cold, it often goes into my chest.
- 13. I had one or more emergency visits to a doctor in the last year because of breathing problems.
- 14. I had one or more overnight hospitalizations due to breathing problems in the last year.

Answer the following if you ever have been diagnosed with asthma:

- 15. I feel like I use my asthma inhaler too often.
- 16. Sometimes I don't like the way my asthma medicine(s) makes me feel.
- 17. My asthma medicine(s) doesn't control my asthma.
- 18. My asthma controls my life more than I would like.
- 19. I feel tension or stress because of my asthma.
- 20. I worry that my asthma affects my health or may even shorten my life.

EXAMINER: PLEASE COMPLETE THIS SECTION

Total number of YES responses _____ FEV₁ percent of predicted _____ %

RECOMMENDATION: Referred _____ Not referred _____

Screening Examiner (Please write clearly) _____

ORIGINAL Form—Screening Program Participant

PINK Copy—Screening Program Coordinator

YELLOW Copy—ACAAI

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Name _____ Birth Date ____ / ____ / ____

Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ (Work) _____

Sex: Male _____ Female _____ **Age:** _____ **Height:** _____ **Weight:** _____

Are you? White _____ Black _____ Hispanic _____ Asian _____ Native Amer. _____ Other _____

Education Completed:

Elementary _____ High School _____ 2 years college _____ 4 years college _____ Graduate degree _____

Do you have allergies? Yes _____ No _____

If so, to what are you allergic? _____

Do you smoke? Yes _____ No _____

Have you ever been diagnosed as having asthma? Yes _____ No _____

If "yes" and you are currently receiving medical care for asthma, what kind of doctor is providing that care?

Pediatrician _____ Internist _____ Family Practice Physician _____

Allergist _____ Pulmonologist _____ Other _____ Not being treated _____

Have you ever been treated by an allergist? Yes _____ No _____ Don't know _____

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Signature _____ Date _____

Signature of parent if participant is under 18.

Signature _____ Date _____

Questionnaire for Kids 8-14

NOTE: Kids ages 8-14 should answer questions themselves.

Name _____

Date ____ / ____ / ____

Please answer the following questions “yes” or “no”:

YES **NO**

1. When I walk or play hard with friends, I have trouble breathing or I cough. YES NO
2. When I walk up hills or stairs, I have trouble breathing or I cough. YES NO
3. I don't like to run or play sports because I have trouble breathing or I cough. YES NO
4. Sometimes I wake up at night with coughing or trouble breathing. YES NO
5. Sometimes I have trouble taking a deep breath. YES NO
6. Sometimes I make wheezing sounds in my chest. YES NO
7. Sometimes my chest feels tight or hurts. YES NO
8. Sometimes I cough a lot. YES NO
9. Being outdoors or around dust or pets makes my breathing worse. YES NO
10. It's hard to breathe in cold weather. YES NO
11. It's hard to breathe when people smoke or there are strong odors. YES NO
12. Colds make me cough or wheeze. YES NO
13. I went to the doctor's office or emergency room for asthma or trouble breathing this year. YES NO
14. I stayed in the hospital overnight for asthma or trouble breathing this year. YES NO

Answer the following if you ever have been told you have asthma:

15. I use my asthma inhaler two or more times a week. YES NO
16. Sometimes my asthma medicine(s) makes me feel bad. YES NO
17. I only take medicine when I don't feel well. YES NO
18. I can't do some things because of my asthma. YES NO
19. I get scared because of my asthma. YES NO
20. I worry that I may die from my asthma. YES NO

EXAMINER: PLEASE COMPLETE THIS SECTION

Total number of YES responses _____ FEV₁ percent of predicted _____ %

RECOMMENDATION: Referred _____ Not referred _____

Screening Examiner (Please write clearly) _____

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PINK Copy—Screening Program Coordinator

YELLOW Copy—ACAAI

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If so, to what are you allergic? _____

Do you smoke? Yes _____ No _____

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I have read, understand and accept the above paragraphs.

Signature _____ Date _____

Signature of parent if participant is under 18.

Signature _____ Date _____

Questionnaire for Children 7 and Under

NOTE: Parents of children 7 and under should answer questions for their child.

Name _____

Date ____ / ____ / ____

Please answer the following questions “yes” or “no”:

YES **NO**

- 1. When walking or playing hard with friends, my child has trouble breathing or coughs. YES NO
- 2. When walking up hills or stairs, my child has trouble breathing or coughs. YES NO
- 3. When running or playing sports, my child has trouble breathing or coughs. YES NO
- 4. Sometimes my child wakes up at night with coughing or trouble breathing. YES NO
- 5. Sometimes my child has trouble taking a deep breath. YES NO
- 6. Sometimes my child makes wheezing sounds. YES NO
- 7. Sometimes my child complains of pain or tightness in the chest. YES NO
- 8. Sometimes my child coughs a lot. YES NO
- 9. Being outdoors or around dust or pets makes my child's breathing worse. YES NO
- 10. It's hard for my child to breathe in cold weather. YES NO
- 11. It's hard for my child to breathe when people smoke or there are strong odors. YES NO
- 12. Colds make my child cough or wheeze. YES NO
- 13. My child went to the doctor's office or emergency room for asthma or trouble breathing this year. YES NO
- 14. My child stayed in the hospital overnight for asthma or trouble breathing this year. YES NO

Answer the following if you ever have been told your child has asthma:

- 15. My child uses an asthma inhaler two or more times a week. YES NO
- 16. Sometimes asthma medicine makes my child feel bad. YES NO
- 17. My child only takes medicine when not feeling well. YES NO
- 18. My child can't do some things because of asthma. YES NO
- 19. My child gets scared because of asthma. YES NO
- 20. I worry that asthma affects my child's health or that my child may die from asthma. YES NO

EXAMINER: PLEASE COMPLETE THIS SECTION

Total number of YES responses _____ FEV₁ percent of predicted _____ %

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