Patient Name:______________________________

Please answer the questions below and give to provider during your visit.

Does your child have Reactive Airway's disease or Asthma? Yes/No

If you answered **NO** please answer questions under section **A**

If you answered **YES** please answer questions under section **B**

**A. Asthma Risk Assessment**

1. Is your child exposed to second hand smoke? Yes / No
2. Does your child smoke? Yes / No
3. Is/Was your child breastfed? Yes / No
4. Does your child have seasonal allergies? Yes / No
5. Does your child have eczema? Yes / No
6. Do any siblings (biological only) of your child have asthma or reactive airways disease? Yes / No
7. Do the biological parents of your child have asthma or reactive airways disease? Yes/No
8. Has your child ever had RSV or Respiratory Synctial Virus or bronchiolitis?

**B. Asthma Impairment Assessment**

1. How often does your child cough or wheeze?
   - A. Less than 2 days a week C. Daily
   - B. More than 2 days a week D. Throughout the day
2. How often does your child wake up at night coughing or wheezing?
   - A. Never
   - B. Less than two times a month
   - C. 3 to 4 times a month
   - D. More than once a week
   - E. Every night
3. How often does your child need a breathing treatment with albuterol/levalbuterol (Xopenex) or their rescue inhaler (Proair, Ventolin, Proventil, Xopenex)?
   - A. Never
   - B. Less than two days in a week
   - C. More than two days in a week
   - D. Every day
   - E. More than once a day
4. Do asthma symptoms interfere with your child's daily activities?
   - A. No C. Asthma causes significant limitations
   - B. Asthma causes minor limitations D. Asthma causes extreme limitations