VIRGINIA PEDIATRIC GROUP, LTD.

Patient Self-Assessment Form - Asthma

Patient Name _____ Today's Date _____

Since your last visit:

1. Has your asthma been worse? No ____ Yes ____
2. Have there been changes in your home, school or work environment?
   (such as a new pet or someone smoking) No ____ Yes ____
3. Have you had times when your symptoms were worse than usual? No ____ Yes ____
4. Has your asthma caused you to miss school or work or reduce or change your activities? No ____ Yes ____
5. How many days per week have you had to use your rescue inhaler? _____
6. Have you had any ER visits, hospital stays or seen a specialist for your asthma? No ____ Yes ____
   Details? _____
7. Do you have any asthma medications you take daily? No ____ Yes ____
   Medications and doses _____
8. Do you miss many doses? No ____ Yes ____
   Why? _____
9. Have your medications caused you any problems?
   (shakiness, nervousness, bad taste, sore throat, upset stomach) No ____ Yes ____
10. Do you need refills for any medication today? No ____ Yes ____
11. Spirometry done last year? No ____ Yes ____
12. Have you been satisfied with your level of asthma control? No ____ Yes ____
13. What concerns about your asthma would you like addressed today?

_____

_____

_____

14. Do you need any school medication forms? No ____ Yes ____

Provider's signature: _____