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Asthma Therapy Assessment

(Adults 18+)

Please answer every question.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

In the past 4 weeks, did you:

Miss any work, school, or normal daily activity because of your asthma? yes ◯ no ◯ unsure ◯

Wake up at night because of asthma? yes ◯ no ◯ unsure ◯

Inhaler for quick relief

Do you use an inhaler for quick relief from asthma symptoms? yes ◯ no ◯ unsure ◯

If yes, in the past 4 weeks, what was the highest number of puffs in 1 day you took of the inhaler?

- 0 ◯
- 1 to 4 puffs ◯
- 5 to 8 puffs ◯
- 9 to 12 puffs ◯
- more than 12 puffs ◯

Inhaler for control

Has your doctor or healthcare provider ever prescribed an asthma inhaler or pill that is not used for quick relief but is used to control your asthma? yes ◯ no ◯ unsure ◯

If yes, which statement best describes how you take this medicine now?

- I take it every day ◯
- I take it some days, but other days I do not ◯
- I used to take it, but now I do not ◯
- I take it only when I have symptoms ◯
- I never take it ◯

Current treatment

Are you dissatisfied with any part of your current asthma treatment? yes ◯ no ◯ unsure ◯

Do you believe that:

Your asthma was well controlled in the past 4 weeks? yes ◯ no ◯ unsure ◯

You are able to take your asthma medicine(s) as directed? yes ◯ no ◯ unsure ◯

Your medicine(s) is useful in controlling your asthma? yes ◯ no ◯ unsure ◯

Today's visit

During this office visit, would you like your doctor to discuss any of the following?
Mark all that apply.

- different types of drugs available to control asthma ◯
- asthma treatment options ◯
- your preferences for taking asthma medicine(s) ◯
- other issue(s) ◯

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