SAMPLE PATIENT SELF-ASSESSMENT SHEET FOR FOLLOW-UP VISITS*

Name:_____ Date:_____

Your Asthma Control

How many days in the past week have you had chest tightness, cough, shortness of breath, or wheezing (whistling in your chest)?

___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

How many nights in the past week have you had chest tightness, cough, shortness of breath, or wheezing (whistling in your chest)?

___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

Do you perform peak flow readings at home? ___ yes ___ no

If yes, did you bring your peak flow chart? ___ yes ___ no

How many days in the past week has asthma restricted your physical activity?

___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

Have you had any asthma attacks since your last visit? ___ yes ___ no

Have you had any unscheduled visits to a doctor, including to the emergency department, since your last visit? ___ yes ___ no

How well controlled is your asthma, in your opinion?

___ very well controlled
___ somewhat controlled
___ not well controlled

Average number of puffs per day of quick-relief medication (short acting beta2-agonist) that you've needed to use recently _____

Taking your medicine

What problems have you had taking your medicine or following your asthma action plan? Please ask the doctor or nurse to review how you take your medicine.

Your questions

What questions or concerns would you like to discuss with the doctor?

How satisfied are you with your asthma care?

____ very satisfied
____ somewhat satisfied
____ not satisfied

* These questions are examples and do not represent a standardized assessment instrument.

Adapted from National Asthma Education and Prevention Program Expert Panel. **Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007**. National Institutes of Health: National Heart, Lung, and Blood Institute; (2007) Fig 4, p 7. http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.htm. Accessed on 3/31/08.

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