Name: _____
Last Name *First Name*

DOB: _____ Gender: M F Student ID: _____

Asthma/ Breathing Questionnaire
(AQ)

Saint Paul Public School

Please complete this form and **return to the health office**. Information provided will be used to create a plan to address your child's health needs in the school setting. Health office staff will work with you and the health care provider to obtain authorization for any medications your child may need at school.

Primary health care provider:	Clinic:	Phone: ( )
Pulmonologist *(if applicable)*:	Clinic:	Phone: ( )

1. Last school year, how many days of school did your child miss due to his/her asthma/breathing problems?
   ___ 0 days ___ 1 - 5 days ___ 6 - 10 days ___ 11+ days

2. In the last year, has your child:
   a. Stayed overnight in the hospital because of breathing problems or asthma: ___ No ___ Yes
   b. Gone to the emergency room because of breathing problems or asthma: ___ No ___ Yes
   c. Gone to the clinic because of breathing problems or asthma: ___ No ___ Yes

3. Asthma symptoms may include wheezing, coughing, shortness of breath, chest tightness, or pain. In the last 4 weeks how often has your child had asthma symptoms, or how much of a problem have asthma symptoms been:
   During the day? ___ 0 - 2 days/week (a) ___ 3 - 6 days/week (b) ___ Everyday/Throughout the day (c)
   During the night? ___ 0 - 1 night/week (a) ___ 2 - 5 nights/week (b) ___ 2 or more nights/week (c)
   During exercise, sports, playing hard, or other activities?
   ___ Not a problem (a) ___ A little problem (b) ___ A big problem/hardly able to do anything (c)

4. In the last 4 weeks, how often has your child used his/her rescue medication *(i.e. albuterol)* for an asthma episode or breathing problem? ___ 0 - 2 days/week (a) ___ 3 - 7 days/week (b) ___ Several times per day (c)

5. In the past 12 months, how many times has your child taken oral steroids *(i.e. prednisone)* for an asthma episode or breathing problem? ___ Never (a) ___ Once (b) ___ 2 times or more (c)

6. What triggers your child's asthma/breathing problem or makes it worse?
   ___ Smoke ___ Grass/flowers/pollen ___ Having a cold/respiratory illness
   ___ Animals/pets ___ Mold ___ Stress or emotional upsets
   ___ Dust/dustmites ___ Changes in weather/very cold or hot air
   ___ Cockroaches ___ Strong smells/perfumes/lotions/cleaning products
   ___ Exercise, sports, or playing hard
   ___ Foods *(which ones)*: _____

7. What are your child's usual signs/symptoms of an asthma episode or breathing problem?
   ___ Wheezing ___ Shortness of breath ___ Difficulty breathing
   ___ Itchy throat ___ Coughing ___ Irritable/crabby
   ___ Chest tightness ___ Waking up at night ___ Stomachache
   ___ Other: _____

8. Please list the medications your child takes for asthma *(everyday medications and medications taken when needed)*.

Medication Name?	How Often does your Child Use It?	Where is it Taken?
		___ Home ___ School
		___ Home ___ School
		___ Home ___ School

_____ _____
Parent/Guardian Signature *Date*