ASTHMA SCREENING
PLEASE ANSWER QUESTIONS BELOW

Date:_____ Location of test/screening:_____

Child's Name: _____
First Last

DOB: _____ Age: _____
Month/Day/Year

Parent/Guardian Name: _____

Address: _____Zip Code: _____

Home Phone : _____ Work Phone : _____

Child's Sex: Male ☐ Female ☐

Child's Race: White ☐ African-American ☐ Asian ☐
Multiracial ☐ Latino ☐ Other ☐

	YES	NO	DON'T KNOW
1) In the past 12 months has your child had wheezing in the chest lasting more than one day?	☐	☐	☐
2) Does your child often cough when sleeping? (night or naptime)	☐	☐	☐
3) Does your child have coughing, wheezing or shortness of breath with running or physical activity?	☐	☐	☐
4) Has your child been treated with medication for asthma?	☐	☐	☐
5) Has the doctor or a health care provider ever said your child has asthma?	☐	☐	☐

For Office Use Only:

☐ Provided Family with Resource List

Does child require follow up? Yes No