AUSTIN REGIONAL CLINIC

# Pediatric Asthma Trigger Assessment

Patient Name: _____ Date: _____

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|---|---|---|
| Does your child cough, wheese, have chest tightness, or feel short of breath year-round? | NO | YES |
| If Yes: | | |
| • Are there pets or animals in your houme, school or day care? | NO | YES |
| • Is there moisture or dampness in any room of your home? | NO | YES |
| • Have you seen mold or smelled musty odors any place in your home? | NO | YES |
| • Have you seen cockroaches in your home? | NO | YES |
| • Do you use a humidifier or swamp cooler in your home? | NO | YES |
| Does your childs coughing, wheezing, chest tightness, or shortness of breath get worse at certain times of the year? | NO | YES |
| Do his/ her symptoms get worse in the: ☐ Winter ☐ Spring ☐ Summer ☐ Summer | | |
| Does your child have a stuffy nose or postnasal drip, either at certain times of the year or year-round? | NO | YES |
| Does your child sneeze often or have itchy, watery eyes? | NO | YES |
| Do you smoke? | NO | YES |
| Does anyone smoke at home or day care? | NO | YES |
| Is a wood-burning stove or fireplace used in your home? | NO | YES |
| Are kerosene, oil or gas stoves or heaters used without vents in your home? | NO | YES |
| Is your child exposed to fumes or odors from cleaning agents, sprays, or other chemicals at home or school? | NO | YES |
| Does your child cough or wheeze during the week, but not on weekends when away from school or daycare? | NO | YES |
| Do your childs eyes and nose get irritated soon after you get to school? | NO | YES |
| Does your child have heartburn? | NO | YES |
| Does food some times come up into your childs throat? | NO | YES |
| Has your child had coughing, wheezing, or shortness of breath at night in the past 4 wks? | NO | YES |
| Does your child vomit then cough or have a wheezy cough at night? | NO | YES |
| Are these symptoms worse after eating? | NO | YES |
| Has your child had wheezing, coughing, or shortness of breath after eating any foods? | NO | YES |
| Does your child cough, wheeze, have chest tightness, or feel short of breath during or after exercise? | NO | YES |
| Is your child taking any prescription medicines or over-the-counter medicines? | NO | YES |
| If yes, which ones? _____ | | |
| Does your child use eye drops? | NO | YES |
| Does your child ever take asprin or other nonsteroidal anti-inflammatory drugs (like Ibuprofen)? | NO | YES |
| Has your child ever had coughing, wheezing, chest tightness, or shortness of breath after taking any medication? | NO | YES |

**When completed, please give to your doctor's nurse.**