Better Asthma Control for Kids

Pre-Visit 2 Survey

Record ID:
Student name:
School:
Study ID:

Section 1: Asthma Control and Risk Assessment

Please help us understand [*student first name*]'s asthma since our last visit *[visit 1 date*].

1. **Since the last time we spoke, how many times has [*student first name*] visited the ER/urgent care or had an urgent doctor's office visit for asthma?**
   - ○ 0
   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5
   - ○ 6
   - ○ 7
   - ○ 8
   - ○ 9
   - ○ 10
   - ○ More than 10
   - ○ Don't know
2. **Since the last time we spoke, how many times has [*student first name*] been hospitalized overnight for asthma?**
   - ○ 0
   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5
   - ○ More than 5
   - ○ Don't know
3. **Since the last time we spoke, how many times has [*student first name*] used oral steroids (prednisone, Orapred) to treat an asthma attack?**
   - ○ 0
   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5
   - ○ 6
   - ○ 7
   - ○ 8
   - ○ 9
   - ○ 10
   - ○ More than 10
   - ○ Don't know

4. **Since the last time we spoke, how many days of school did [*student first name*] miss because of asthma?**
    - 0
    - 1 - 2 days
    - 3 - 5 days
    - 6 - 10 days
    - 11 - 15 days
    - 15 or more days Don't Know
5. **Since the last time we spoke, how many days of work did you or other caregivers miss because of [*student first name*]'s asthma?**
    - 0
    - 1 - 2 days
    - 3 - 5 days
    - 6 - 10 days
    - 11 - 15 days
    - 15 or more days Don't Know
6. **In the past 4 weeks, how often has [*student first name*] used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?**
    - Never
    - 1-2 times/month
    - 3 or more times/month
    - 2 or more times/week
    - Every night
7. **In the past 4 weeks, how often has [*student first name*] had coughing, trouble breathing, or wheezing in the morning or during the day?**
    - Never
    - 1-2 days/week
    - 3 or more days/week but not every day
    - Everyday
8. **In the past 4 weeks, how often has [*student first name*] awakened at night because of coughing, trouble breathing, or wheezing?**
    - Never
    - 1-2 days/week
    - 3 or more days/week but not every day
    - Every day
9. **In the past 4 weeks, how often has [*student first name*]'s asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?**
    - Never
    - Rarely
    - Sometimes
    - Often
    - All of the time

Section 2: Changes

10. Did [*student first name*]'s school change since we spoke last time?

- ○ Yes
- ○ No

11. Did [*student first name*] move to a new location since we spoke last time?

- ○ Yes
- ○ No

12. Has the *primary caregiver/parent/guardian changed for [student first name]?*

- ○ Yes
- ○ No

13. Has there been any changes to [*student first name*]'s insurance status?

- ○ Yes
- ○ No

14. Has the doctor/healthcare provider changed for [*student first name*]?

- ○ Yes
- ○ No

15. Has the medication [*student first name*] was using changed?

- ○ Yes
- ○ No

16. Does anyone in [*student first name*]'s immediate circle smoke?

- ○ Yes
- ○ No

17. Who smokes? (*Check all that apply*)

- ☐ Student
- ☐ Mother
- ☐ Father
- ☐ Brother/Sister
- ☐ Uncle/Aunt
- ☐ Grandparents
- ☐ Friends/Guests
- ☐ Other →

17a. Who else smokes?

_____

18. Where do they smoke (*Check all that apply*)

- ☐ Inside the home
- ☐ Inside the car
- ☐ Outside

19. Does anyone in [*student first name*]'s immediate circle vape?

- ○ Yes
- ○ No

20. Who vapes? (*Check all that apply*)

- ☐ Student
- ☐ Mother
- ☐ Father
- ☐ Brother/Sister
- ☐ Uncle/Aunt
- ☐ Grandparents
- ☐ Friends/Guests
- ☐ Other →

20.a Who else vapes? _____

21. Where do they vape? (*Check all that apply*)

- ☐ Inside the home
- ☐ Inside the car
- ☐ Outside