



Pre-Visit 3 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 2 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



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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



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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