(Patient Interview completed)

DEMOGRAPHY

01 1. What is your date of birth? ____ ____/ ____ ____/ ____ ____
month day year

02 2. What is your race?

- ❑1 American Indian or Alaskan Native
- ❑2 Asian or Pacific Islander
- ❑3 Black, not of Hispanic Origin
- ❑4 White, not of Hispanic Origin
- ❑5 Hispanic
- ❑6 Other_____

03 3. What is your sex?

- ❑1 Male
- ❑2 Female

ASTHMA HISTORY

04 4. Approximately how old were you when your asthma first appeared? (*Check one box only*)

- ❑1 less than 10 years old
- ❑2 10-19 years old
- ❑3 20-29 years old
- ❑4 30-39 years old
- ❑5 40-49 years old
- ❑6 50 years or more
- ❑8 unknown

05 5. How many years have you had asthma? (*Check one box only*)

- ❑1 less than 1 year
- ❑2 1-4 years
- ❑3 5-9 years
- ❑4 10-14 years
- ❑5 15 years or more
- ❑8 unknown

6. Have you ever had an asthma attack caused by:

06A	6a.	A respiratory infection?	❑1 Yes ❑0 No
06B	6b.	Cold air?	❑1 Yes ❑0 No
06C	6c.	Tobacco smoke?	❑1 Yes ❑0 No
06D	6d.	Allergies (other than tobacco smoke)?	❑1 Yes ❑0 No
06E	6e.	Exercise?	❑1 Yes ❑0 No
06F	6f.	Aspirin?	❑1 Yes ❑0 No

07 — 7. Are there any other conditions that worsen your asthma? ❑1 Yes ❑0 No

If ***Yes***, describe _____

8. In the last 12 months, how many: (*Enter '0' if none*)

08A	8a.	Asthmatic episodes have you had that required emergency care or an office visit?	___ ___
08B	8b.	Hospitalizations have you had due to asthma?	___ ___
08C	8c.	Courses of oral corticosteroid therapy have you taken?	___ ___

09 — 9. Have you missed any days of work or school due to asthma in the last 12 months? ❑1 Yes ❑0 No ❑9 N/A

09A — If ***Yes***, record the number of days missed. ___ ___

10. Have any of your immediate **blood relatives** been told by a physician that they have asthma? (*Check the 'N/A' box if the patient is adopted or does not have children, siblings, etc.*)

10A	10a.	Mother	❑1 Yes ❑0 No ❑9 N/A
10B	10b.	Father	❑1 Yes ❑0 No ❑9 N/A
10C	10c.	Brothers or Sisters	❑1 Yes ❑0 No ❑9 N/A
10D	10d.	Child(ren)	❑1 Yes ❑0 No ❑9 N/A

PRIOR ASTHMA TREATMENT

Next, I will read a list of asthma medications. Indicate if you have used the medication. If you have, please indicate to the best of your knowledge, the date last taken.

			If Yes, indicate date medication was last taken month / day / year
11 11A	11.	Short acting Inhaled Beta-Agonists (MDI) (**Bronkaid Mist, Duo-Medihaler, Medihaler-Epi, Primatene Mist and others**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
12 12A	12.	Intermediate acting Inhaled Beta-Agonists (MDI) (**Alupent, Brethaire, Brethine, Bronkometer, Maxair, Metaprel, Proventil, Tornalate, Ventolin and others)**	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
13 13A	13.	Long acting Inhaled Beta-Agonists (MDI) (**Serevent**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
14 14A	14.	Asthma medication via a Nebulizer Machine	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
15 15A	15.	Intermediate acting Oral Beta-Agonists (**Alupent, Brethine, Bricanyl, Metaprel, Proventil, Ventolin and others**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
16 16A	16.	Long acting Oral Beta-Agonists (**Repetabs, Volmax**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
17 17A	17.	Short acting Oral Theophylline (**Aminophylline and others)**	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
18 18A	18.	Sustained release Oral Theophylline (**Slo-bid, Theo-Dur, Uniphyl and others**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
19 19A	19.	Inhaled Anticholinergic (**Atrovent**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
20 20A	20.	Anti-allergic Medications (**Intal, Nasalcrom, Gastrocrom, Tilade and others**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __
21 21A	21.	Anti-Inflammatory Medications (**AeroBid, Azmacort, Beclovent, Vanceril and others**)	❑$_1$Yes ❑$_0$ No ❑$_8$ Unknown	__ __/__ __/__ __

Have you had any diseases or illnesses related to the following areas?

				If Yes, Comment
22	22.	Skin	❑1 Yes ❑0 No	_____
23	23.	Blood, Lymph, or Immune Systems	❑1 Yes ❑0 No	_____
24	24.	Eyes	❑1 Yes ❑0 No	_____
25	25.	Ears, Nose, or Throat	❑1 Yes ❑0 No	_____
26	26.	Breasts	❑1 Yes ❑0 No	_____
27	27.	Tissue or Glands	❑1 Yes ❑0 No	_____
28	28.	Respiratory System (excluding asthma)	❑1 Yes ❑0 No	_____
29	29.	Cardiovascular System	❑1 Yes ❑0 No	_____
30	30.	Liver or Pancreas	❑1 Yes ❑0 No	_____
31	31.	Kidneys or Urinary Tract System	❑1 Yes ❑0 No	_____
32	32.	Reproductive System	❑1 Yes ❑0 No	_____
33	33.	Stomach or Intestines	❑1 Yes ❑0 No	_____
34	34.	Muscles or Bones	❑1 Yes ❑0 No	_____
35	35.	Nervous System	❑1 Yes ❑0 No	_____
36	36.	Psychiatric	❑1 Yes ❑0 No	_____