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**PATIENT SELF-ASSESSMENT FORM
FOR ENVIRONMENTAL AND OTHER FACTORS
THAT CAN MAKE ASTHMA WORSE**

Patient Name: _____ Date: _____

Do you cough, wheeze, have chest tightness, or feel short of breath year-round? (If no, go to next question)

No ____ Yes ____

If yes:

Are there **pets** or animals in your home, 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 coughing, wheezing, chest tightness, or shortness of breath get worse at certain times of the year? (If no, go to next question)

No ____ Yes ____

If yes:

Do your symptoms get worse in the

Early spring? (Trees) No ____ Yes ____

Late spring? (Grasses) No ____ Yes ____

Late summer to autumn? (Weeds) No ____ Yes ____

Summer and fall? (Altemaria, Cladosporium) No ____ Yes ____

Do you **smoke**? No ____ Yes ____

Does anyone smoke at home, work, 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 ____

Are you exposed to **fumes or odors** from cleaning agents, sprays, or other chemicals?
No ____ Yes ____

Do you cough or wheeze during the week, but not on weekends when away from **work or school**?

No ____ Yes ____

Do your eyes and nose get irritated soon after you get to work or school?

No ____ Yes ____

Do your coworkers or classmates have symptoms like yours?
No ____ Yes ____

Are isocyanates, plant or animal products, smoke, gases, or fumes?
No ____ Yes ____

Is it cold, hot, dusty, or humid where you work? No ____ Yes ____

Do you have a **stuffy nose** or postnasal drip, either at certain times of the year or year-round?

No ____ Yes ____

Do you sneeze often or have itchy, watery eyes? No ____ Yes ____

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Do you have heartburn ?	No ____	Yes ____
Does food sometimes come up into your throat?	No ____	Yes ____
Have you had coughing, wheezing, or shortness of breath at night in the past 4 weeks?	No ____	Yes ____
Does your infant vomit then cough or have wheezy cough at night?	No ____	Yes ____
Are these symptoms worse after feeding?	No ____	Yes ____
Have you had wheezing, coughing, or shortness of breath after eating shrimp, dried fruit, or canned or processed potatoes?	No ____	Yes ____
After-drinking beer or wine?	No ____	Yes ____
Are you taking any prescription medicines or over-the-counter medicines?	No ____	Yes ____
If yes, which ones? _____		
Do you use eye drop?	No ____	Yes ____
Do you use any medicines that contain beta-blockers (e.g., blood pressure medicine)?	No ____	Yes ____
Do you ever take aspirin or other nonsteroidal anti-inflammatory drugs (like ibuprofen)?	No ____	Yes ____
Have you ever had coughing, wheezing, chest tightness, or shortness of breath after taking any medication?	No ____	Yes ____
Do you cough, wheeze, have chest tightness, or feel short of breath during or after exercising?	No ____	Yes ____

Fom the Practical Guide for the Diagnosis and Management of Asthma NIH/NHLBI October 1997 Courtesy
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