FREEDOM HEALTH

P.O. Box 153178, Tampa, FL 33684
Health and Wellness Material

Asthma Disease Management Assessment

Date of Birth:
Phone#:

Date:
Member Name:
Member Address:
City State Zip:

ID#:

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? ❑ Yes ❑ No

If you received this form in error and don't have this health, check the box and return the form to us in the supplied envelope without answering any of the questions below. ❑ No, I don't have Asthma.

1. How often do you experience shortness of breath? (check one) ❑ Daily ❑ 1-2 times a week ❑ 2-4 times a month ❑ Never
2. How often do you experience wheezing? (check one) ❑ Daily ❑ 1-2 times a week ❑ 2-4 times a month ❑ Never
3. In the past 4 weeks, how often did your Asthma interfere with your daily activities? (check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always
4. Does your Asthma prevent you from getting a good night's sleep? (check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always
5. How many medications do you take for your Asthma? (check one) ❑ None ❑ 1 ❑ 2-3 ❑ 4 or more
6. How often do you use a rescue inhaler (ex. Albuterol or ProAir)? (check one) ❑ Daily ❑ 1-2 times a week ❑ 2-4 times a month ❑ Never
7. Are you on a daily inhaled steroid? (ex. Advair or Pulmocort) ❑ Yes ❑ No
8. How many times in the past year did you need to take steroids by mouth (ex. Prednisone)? (check one) ❑ Daily ❑ 1-2 times a week ❑ 2-4 times a month ❑ Never
9. How many pills do you take for your Asthma? (check one) ❑ 0 ❑ 1-2 pills ❑ 3-4 pills ❑ More than 4 pills
10. What doctor takes care of your Asthma? (check all that apply) ❑ Primary Care Doctor ❑ Allergist ❑ Pulmonologist
11. How many times in the past year have you seen your doctor for your Asthma? (check one) ❑ None ❑ 1-2 times ❑ 3-4 times ❑ 5 times or more
12. How many times in the past year have you been to the emergency room due to your Asthma? (check one) ❑ None ❑ 1-2 times ❑ 3-4 times ❑ 5 times or more

Asthma Disease Management Assessment *(continued)*

13. How many times in the past year have you been hospitalized due to your Asthma?
(check one) ❑ None ❑ 1-2 times ❑ 3-4 times ❑ 5 times or more

14. How often do you use your peak flow meter?
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

15. How often do you have to give yourself a breathing treatment with a nebulizer?
(check one) ❑ Never ❑ Rarely ❑ Sometimes ❑ Very Often ❑ Always

16. Do you smoke? ❑ Yes ❑ No

17. Does someone in your household smoke? ❑ Yes ❑ No

18. Do you think your Asthma has become better or worse over the past year?
(check one) ❑ Better ❑ Worse ❑ Stayed the same

19. Do you have a written plan from your doctor of what to do when you start to wheeze? ❑ Yes ❑ No

20. How would you rate your ability to take care of yourself with the support you have in place?
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor