

virtual Visit 2

Case ID	488
Virtual Home Visit 2	
Date of visit 2	<input type="text"/> Y-M-D
Name of Interviewer	<input type="text"/>
* must provide value	
When did you/your child last have symptoms?	<input type="text"/>
How would you rate your/your child's asthma during the past month?	<input type="radio"/> out of control <input type="radio"/> poorly controlled <input type="radio"/> somewhat controlled <input type="radio"/> well controlled <input type="radio"/> I don't know
In the past month how many days of work/school/daycare have/has you/your child missed due to asthma?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> greater than 5
In the past month, how often did your/your child's asthma keep you from getting as much work done? (at home, work, or school)	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> greater than 5
In the last month, how many days have/has you/the child been working harder to breathe?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> greater than 5
In the last month, how many days did asthma symptoms wake you/your child up in the middle of the night or earlier than usual in the morning?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> greater than 5
In the past month, how many times has your/your child's asthma caused you to call your doctor?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> greater than 5
In the past month, how many times has your/your child's asthma caused you to go to the Emergency Room or Urgent Care Clinic?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> greater than 5
In the past month, besides emergency room/urgent care visits, how many times has your/your child's asthma caused you to go to your doctor's office or clinic for worsening of symptoms?	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2

In the past month, how many times have/has you/your child been admitted overnight in a hospital due to asthma?

- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5
- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ greater than 5

In the past month how many days did your child's asthma keep you from performing normal daily activities (at home, work or school)?

Did you make any changes to the frequency or way in which you clean and maintain your home over the last month?

- ☐ Yes
- ☐ No

If yes, what changes have you made?

Do you think that there are fewer asthma triggers in the home because of the changes to your cleaning practices?

- ☐ yes
- ☐ No
- ☐ Unsure

Have you implemented any of the green cleaning methods we have suggested?

- ☐ Yes
- ☐ No

If so, which ones and have you found them to be helpful?

Date of Virtual Home visit 3
Schedule the next visit now with the patient

M-D-Y H:M

* must provide value

Form Status

Complete?

Incomplete ▼