

Participant ID: _____

Visit: _____

Staff's Initials

--	--	--

Date:

--	--

 /

--	--

 /

--	--

Month Day Year

Airways Outcomes

- Notes:
- Questions are to be directed towards parent from age 1-12 and child/participant from age 13+
 - Questionnaire should be administered before the Asthma Control Test (ACT child or regular) and Patient Oriented Eczema Measure (POEM)
 - The following questions ask about symptoms and conditions related to rhinitis, asthma and wheezing, eczema (atopic dermatitis), food allergy, anaphylaxis, medications for allergy, asthma, cough or wheeze, and respiratory infections and related surgeries.

Rhinitis

[Ages: Early childhood, middle childhood, adolescence, and adult – Parent to complete for child in early and middle childhood, preference for child to answer in adolescence]

[INTERVIEWER] " All of the next questions are about nasal problems which occur when [you do not/PARTICIPANT does not] have a cold or the flu."

1. [Have you/Has PARTICIPANT] ever had a problem with sneezing or a runny or blocked (stuffy) nose, when [you/PARTICIPANT] DID NOT have a cold or the flu?
 - 1 Yes
 - 0 No → **SKIP TO Q8**

2. In the past 12 months, [have you/has PARTICIPANT] had a problem with sneezing or a runny or blocked (stuffy) nose when [you/PARTICIPANT] DID NOT have a cold or the flu?
 - 1 Yes
 - 0 No → **SKIP TO Q8**

3. In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?
 - 1 Yes
 - 0 No

4. In which of the past 12 months did this nose problem occur? **[Select all that apply.]**

<input type="checkbox"/> 1 January	<input type="checkbox"/> 5 May	<input type="checkbox"/> 9 September
<input type="checkbox"/> 2 February	<input type="checkbox"/> 6 June	<input type="checkbox"/> 10 October
<input type="checkbox"/> 3 March	<input type="checkbox"/> 7 July	<input type="checkbox"/> 11 November
<input type="checkbox"/> 4 April	<input type="checkbox"/> 8 August	<input type="checkbox"/> 12 December

5. In the past 12 months, how much did this nose problem interfere with [your/PARTICIPANT's] daily activities?
 - 1 Not at all

- 2 A little
- 3 A moderate amount
- 4 A lot

6. In the following list, what sets-off or triggers any of the nose problems that [you/PARTICIPANT] reported above?

- a. Cats 1 Yes 0 No .d Do not know
- b. Dogs 1 Yes 0 No .d Do not know
- c. Other animals 1 Yes 0 No .d Do not know
- 6c1. Specify: _____
- d. Dusty places 1 Yes 0 No .d Do not know
- e. Moldy places..... 1 Yes 0 No .d Do not know
- f. Cold air 1 Yes 0 No .d Do not know
- g. Cigarette or cig ar smoke..... 1 Yes 0 No .d Do not know
- h. Strong odors 1 Yes 0 No .d Do not know
- i. Pollen/grass/trees 1 Yes 0 No .d Do not know
- j. Foods..... 1 Yes 0 No .d Do not know

7. At what age did [your/PARTICIPANT's] nose problems start?

Age in years: ____

8. [Have you/Has PARTICIPANT] ever had hay fever, allergic rhinitis, or allergies in the nose?

- 1 Yes
- 0 No → **SKIP TO NEXT SECTION**

9. Has a doctor ever told [you/PARTICIPANT] that [you have/PARTICIPANT has] hay fever, allergic rhinitis, or allergies in the nose?

- 1 Yes
- 0 No

Wheezing and Asthma

[Ages: Early childhood, middle childhood, adolescence, and adult – Parent to complete for child through middle childhood, preference for child to answer in adolescence]

1. [Have you/Has PARTICIPANT] ever had wheezing or whistling in the chest at any time in the past?

- 1 Yes
- 0 No → **SKIP TO Q6**

2. [Have you/Has PARTICIPANT] had wheezing or whistling in the chest in the past 12 months?

- 1 Yes
- 0 No → **SKIP TO Q6**

3. How many attacks of wheezing [have you/has PARTICIPANT] had in the past 12 months?

- 1 None
- 2 1 to 3
- 3 4 to 12

⁴ More than 12

4. In the past 12 months, how often, on average, has [your/PARTICIPANT'S] sleep been disturbed due to wheezing?

¹ Never woken with wheezing

² Less than one night per week

³ One or more nights per week

5. In the past 12 months, has wheezing ever been severe enough to limit [your/PARTICIPANT'S] speech to only one or two words at a time between breaths?

¹ Yes

⁰ No

6. [Have you/Has PARTICIPANT] ever had asthma?

¹ Yes

⁰ No

7. In the past 12 months, has [your/PARTICIPANT'S] chest sounded wheezy during or after exercise?

¹ Yes

⁰ No

8. In the past 12 months, [have you/has PARTICIPANT] had a dry cough at night, apart from a cough associated with a cold or chest infection?

¹ Yes

⁰ No

9. Has a doctor or other health care provider ever told [you/PARTICIPANT] that [you have/PARTICIPANT has] asthma?

¹ Yes

⁰ No → **SKIP TO NEXT SECTION**

10. What was [your/PARTICIPANT'S] age when a doctor or healthcare provider told [you/PARTICIPANT] that [you/PARTICIPANT] had asthma?

Age in years: ____ ____

11. [Do you/Does PARTICIPANT] still have asthma?

¹ Yes [**Complete ACT/CACT form**]

⁰ No

12. [Have you/Has PARTICIPANT] ever been hospitalized for asthma or a severe episode of wheezing or whistling in the chest at any time in the past? Do not include emergency room visits.

¹ Yes

⁰ No → **SKIP TO Q15**

13. How many times [have you/has PARTICIPANT] been hospitalized overnight for asthma or a severe episode of wheezing or whistling in the chest, not including emergency room visits?

Number of times: ____ ____

14. In the past 12 months, [have you/has PARTICIPANT] been hospitalized for asthma or a severe episode of wheezing or whistling in the chest? Do not include emergency visits.

- Yes
- No

15. During the past 12 months, [have you/has PARTICIPANT] had to visit an emergency room or urgent care center because of [your/PARTICIPANT'S] asthma?

- Yes
- No

16. [Have you/Has PARTICIPANT] ever been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

- Yes
- No → **SKIP TO Q20**

17. How many times [have you/has PARTICIPANT] been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

Number of times: ____

18. In the past 12 months, [have you/has PARTICIPANT] been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

- Yes
- No → **SKIP TO Q20**

19. In the past 12 months, how many times [have you/has PARTICIPANT] been treated with an oral or injected steroid for treatment of a severe wheezing or asthma attack?

Number of times: ____

20. In the following list, what sets-off or triggers any of [your/PARTICIPANT'S] asthma or wheezing symptoms?

- a. Cats Yes No Do not know
- b. Dogs Yes No Do not know
- c. Other animals Yes No Do not know
 - c1. Specify: _____
- d. Dusty places Yes No Do not know
- e. Moldy places..... Yes No Do not know
- f. Cold air Yes No Do not know
- g. Cigarette or cigar smoke..... Yes No Do not know
- h. Exercise..... Yes No Do not know
- i. Pollen..... Yes No Do not know
- j. Foods..... Yes No Do not know
- k. Indoor wood smoke (e.g., fireplaces, woodstoves)..... Yes No Do not know
- l. Weather changes Yes No Do not know

21. During which months [do you/does PARTICIPANT] get asthma, wheezing, or whistling in the chest symptoms? **[Select all that apply.]**

- | | | |
|-------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> 1 January | <input type="checkbox"/> 5 May | <input type="checkbox"/> 9 September |
| <input type="checkbox"/> 2 February | <input type="checkbox"/> 6 June | <input type="checkbox"/> 10 October |
| <input type="checkbox"/> 3 March | <input type="checkbox"/> 7 July | <input type="checkbox"/> 11 November |
| <input type="checkbox"/> 4 April | <input type="checkbox"/> 8 August | <input type="checkbox"/> 12 December |

Eczema (Atopic Dermatitis)

[Ages: Infancy through adult – Parent to complete for child through middle childhood, preference for child to answer in adolescence]

1. [Have you/has PARTICIPANT] ever had an itchy rash which was coming and going for at least six months?
 - 1 Yes
 - 0 No → **SKIP TO Q7**

 2. [Have you/has PARTICIPANT] had this itchy rash at any time in the past 12 months?
 - 1 Yes
 - 0 No

 3. Has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck, ears, or eyes?
 - 1 Yes
 - 0 No

 4. At what age did this itchy rash first occur?

Age in years: ____ ____
- [SKIP Q5 AND Q6 IF “NO” IN Q2]**
5. Has this itchy rash cleared completely at any time during the past 12 months?
 - 1 Yes
 - 0 No

 6. In the past 12 months, how often, on average, [have you/has PARTICIPANT] been kept awake at night by this itchy rash?
 - 1 Never in the past 12 months
 - 2 Less than one night per week
 - 3 One or more nights per week

 7. [Have you/Has PARTICIPANT] ever had eczema (also called atopic dermatitis)?
 - 1 Yes **[Complete POEM form]**
 - 0 No → **SKIP TO NEXT SECTION**

 8. Has a doctor or health care provider ever said that [you have/PARTICIPANT has] eczema or atopic dermatitis?
 - 1 Yes **[Complete POEM form]**
 - 0 No

Food Allergy

[Ages: Infancy through adult – Parent to complete for child through middle childhood, preference for child to answer in adolescence]

1. Do you believe that [you have/PARTICIPANT has] a food allergy?

Yes

No

2. Has a doctor or other health care provider said that [you have/PARTICIPANT has] food allergies?

Yes

No

[IF "YES" to Q1 OR Q2, GO TO Q3; IF NO TO BOTH, SKIP TO NEXT SECTION]

3. I'm going to read a list of foods. For each food please let me know whether you believe [you are/ PARTICIPANT is] allergic, whether your doctor or healthcare provider has said [you are/PARTICIPANT is] allergic, or whether [you have never/PARTICIPANT has never] tried the food.

[In the table below, mark an "X" next to the foods in the "You/Participant" column that the caretaker/participant believes they are allergic to. Mark an "X" in the "Doctor/Healthcare Provider" column for the foods that a doctor or other healthcare provider has said the participant is allergic to. Mark an "X" in the column "Never tried" if participant has never tried the food.]

	Foods	You/Participant	Doctor/Healthcare Provider	Never tried
3a.	Egg			
3b.	Milk			
3c.	Peanut			
3d.	Tree nuts (e.g., walnut, almond, hazelnut, cashew)			
3e.	Wheat			
3f.	Soy			
3g.	Shellfish (e.g., shrimp, lobster, crab, mussels)			
3h.	Fish (e.g., salmon, tuna, cod)			
3i.	Other _____			
3j.	Other _____			

[ONLY ANSWER Q4-Q10 FOR FOODS SELECTED EITHER IN "YOU/PARTICIPANT" OR "DOCTOR/HEALTHCARE PROVIDER" COLUMNS IN Q3]

4. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating eggs. **[Select all reactions that apply.]**

No reaction

Hives

Swelling

Vomiting or stomach pain

Diarrhea

- 6 Cough, wheeze, or chest tightness
- 7 Loss of consciousness
- 8 Worsened eczema
- 9 Other reaction, please specify: _____

5. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of **drinking milk**. **[Select all reactions that apply.]**

- 1 No reaction
- 2 Hives
- 3 Swelling
- 4 Vomiting or stomach pain
- 5 Diarrhea
- 6 Cough, wheeze, or chest tightness
- 7 Loss of consciousness
- 8 Worsened eczema
- 9 Other reaction, please specify: _____

6. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating **peanuts**. **[Select all reactions that apply.]**

- 1 No reaction
- 2 Hives
- 3 Swelling
- 4 Vomiting or stomach pain
- 5 Diarrhea
- 6 Cough, wheeze, or chest tightness
- 7 Loss of consciousness
- 8 Worsened eczema
- 9 Other reaction, please specify: _____

7. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating **tree nuts (e.g., walnut, almond, hazelnut, cashew)**. **[Select all reactions that apply.]**

- 1 No reaction
- 2 Hives
- 3 Swelling
- 4 Vomiting or stomach pain
- 5 Diarrhea
- 6 Cough, wheeze, or chest tightness
- 7 Loss of consciousness
- 8 Worsened eczema
- 9 Other reaction, please specify: _____

8. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating **wheat**. **[Select all reactions that apply.]**

- 1 No reaction
- 2 Hives
- 3 Swelling
- 4 Vomiting or stomach pain
- 5 Diarrhea
- 6 Cough, wheeze, or chest tightness
- 7 Loss of consciousness
- 8 Worsened eczema
- 9 Other reaction, please specify: _____

9. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating **soy**. **[Select all reactions that apply.]**

- 1 No reaction
- 2 Hives
- 3 Swelling
- 4 Vomiting or stomach pain
- 5 Diarrhea
- 6 Cough, wheeze, or chest tightness
- 7 Loss of consciousness
- 8 Worsened eczema
- 9 Other reaction, please specify: _____

10. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating **shellfish (e.g., shrimp, lobster, crab, mussels)**. **[Select all reactions that apply.]**

- 1 No reaction
- 2 Hives
- 3 Swelling
- 4 Vomiting or stomach pain
- 5 Diarrhea
- 6 Cough, wheeze, or chest tightness
- 7 Loss of consciousness
- 8 Worsened eczema
- 9 Other reaction, please specify: _____

11. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating **fish (e.g., salmon, tuna, cod)**. **(Select all reactions that apply.)**

- 1 No reaction
- 2 Hives

- ³ Swelling
- ⁴ Vomiting or stomach pain
- ⁵ Diarrhea
- ⁶ Cough, wheeze, or chest tightness
- ⁷ Loss of consciousness
- ⁸ Worsened eczema
- ⁹ Other reaction, please specify: _____

12. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating [piped text from "Other" in Q3i].
[Select all reactions that apply.]

- ¹ No reaction
- ² Hives
- ³ Swelling
- ⁴ Vomiting or stomach pain
- ⁵ Diarrhea
- ⁶ Cough, wheeze, or chest tightness
- ⁷ Loss of consciousness
- ⁸ Worsened eczema
- ⁹ Other reaction, please specify: _____

13. Please specify the reaction(s) that [you/PARTICIPANT] experienced within 2 hours of eating [piped text from "Other" in Q3j].
[Select all reactions that apply.]

- ¹ No reaction
- ² Hives
- ³ Swelling
- ⁴ Vomiting or stomach pain
- ⁵ Diarrhea
- ⁶ Cough, wheeze, or chest tightness
- ⁷ Loss of consciousness
- ⁸ Worsened eczema
- ⁹ Other reaction, please specify: _____

Anaphylaxis

[Ages: Infancy through adult – Parent to complete for child through middle childhood, preference for child to answer in adolescence]

1. [Do you/Does PARTICIPANT] have a history of anaphylaxis? *Symptoms include trouble breathing, swelling of the lips, or low blood pressure. Anaphylaxis may also require treatment with epinephrine.*

- ¹ Yes
- ⁰ No

Medications for Allergies, Asthma, Cough, or Wheeze

1. [Do you/Does PARTICIPANT] use any medications for treatment of hay fever, allergic rhinitis, or allergies in the nose?

- ¹ Yes
- ⁰ No → **SKIP TO Q2**

1a. If yes, which ones?

- ¹ Oral antihistamine (e.g., loratadine [Claritin], cetirizine [Zyrtec], diphenhydramine [Benadryl], fexofenadine [Allegra])
- ² Nasal steroid (e.g., fluticasone [Flonase], triamcinolone [Nasacort], budesonide [Rhinocort])
- ³ Montelukast (e.g., Singulair)
- ⁴ Other, please list: _____

2. [Do you/Does PARTICIPANT] use any medications for treatment of recurrent cough, recurrent wheezing, or asthma?

- ¹ Yes
- ⁰ No → **SKIP TO NEXT SECTION**

2a. If yes, which ones?

- ¹ Albuterol (e.g., Proventil, Proair)
- ² Inhaled steroid (e.g., Flovent, Pulmicort, Asmanex)
- ³ Combination inhaled steroid and long-acting beta agonist (e.g., Advair, Dulera, Symbicort)
- ⁴ Montelukast (e.g., Singulair)
- ⁵ Monoclonals or biologics (e.g., mepolizumab, omalizumab)
- ⁶ Other, please list: _____

Respiratory Infections

[Ages: Infancy through adult – Parent to complete for child through middle childhood, preference for child to answer in adolescence]

1. [Have you/Has PARTICIPANT] ever been diagnosed with bronchiolitis?

- ¹ Yes
- ⁰ No

2. [Have you/Has PARTICIPANT] had any of the following surgeries?

		Yes	If yes, at what age(s)?	No
2a.	Tonsils removed	1		0
2b.	Adenoids removed	1		0
2c.	Ear tubes placed	1		0

3. In the past 12 months, [have you/has PARTICIPANT] been diagnosed with a sinus infection?

- ¹ Yes
- ⁰ No → **SKIP TO Q4**

3a. If yes, how many times ____

4. In the past 12 months, [have you/has PARTICIPANT] been diagnosed with an ear infection (also called otitis media)?

Yes

No → **SKIP TO Q5**

4a. If yes, how many times ____

5. In the past 12 months, [have you/has PARTICIPANT] been diagnosed with croup?

Yes

No → **SKIP TO Q6**

5a. If yes, how many times ____

6. In the past 12 months, [have you/has PARTICIPANT] been diagnosed with pneumonia or bronchitis?

Yes

No

6a. If yes, how many times ____