PEDIATRIC ASTHMA
RESIDUAL CAPACITY QUESTIONNAIRE

Child's Name: _____

SSN:_____ Age: _____

This form collects facts for evaluating the severity of a child's Asthma. The information obtained in this questionnaire with be utilized to determine if child meets or has the medical equivalence of the disabling functional consequences of the impairments listed in the social security disability regulations.

1. How long have you provided services to the child?

2. Please state your relationship to the child (e.g. teacher, therapist, counselor, physician - please indicate area of practice, medical specialist etc.)

3. Please list any medications the child is currently taking and/or has taken in the past. Please include dose, frequency, duration, start date, and stop date of each medication.

4. Please list any medication side effects experienced by the child.

5. Is patient currently using a nebulizer?

Frequency/duration?

6. Is patient using inhalers?

Frequency/duration?

7. Please check the level of asthma that the child has currently and if it has varied in degree all that apply, indicating the time frame for each degree.

____Intermittent

____Mild

____Moderate

____Severe Persistent (or "chronic")

8. Does the child have persistent low-grade wheezing?

9. Does child use a Peak Flow meter at home?

What is the expected capacity the child will reach with the peak flow meter?

10. What is the actual capacity the child reaches when asthma is under control?

When ill?

11. Has child had a pulmonary function test?

When?

12. What were the absolute values of each test? (liters/min.)

13. What have been the 02 saturation ranges on room air?

on oxygen?

14. How many Asthma Attacks requiring medical attention in addition to regular treatment, has the child had in the past year?

15. How many hospitalizations has the child had for asthma in the past year?

For pneumonias?

For Bronchitis?

16. Has the child's growth and development been effected by his/her asthma?

17. Please comment on any additional treatment or relevant information that would be helpful to understanding the nature and severity of the asthma.

TREATING SOURCE: _____

ADDRESS: _____
_____

DATE: _____