New York State Department of Health
Healthy Neighborhoods Program
Home Intervention Form - Asthma Assessment

COUNTY | | | | ID# | | | | | |

Visit Type ○ Initial ○ Revisit

○ Adult ○ Child - ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Complete this form for each adult or child with asthma or asthma symptoms.*
Asthma revisits should be made 3-6 months after the last asthma visit.

Potential asthma triggers	Status
1) Does anyone smoke inside the home?	○ Y ○ N ○ U
2) Is there evidence of significant dust accumulation?	○ Y ○ N ○ U
3) Are there rats? (evidence or reported)	○ Y ○ N ○ U
4) Are there mice? (evidence or reported)	○ Y ○ N ○ U
5) Are there cockroaches? (evidence or reported)	○ Y ○ N ○ U
6) Is there evidence of mold or mildew?	○ Y ○ N ○ U
7) Are there any pets with fur or feathers?	○ Y ○ N ○ U
8) If yes to pets, does s/he sleep in the same room as the pet(s) with fur or feathers?	○ Y ○ N ○ U

Asthma diagnosis and symptoms	Status
1) Has s/he ever been told by a doctor or other health professional that s/he has asthma?	○ Y ○ N ○ U
2) Number of days that s/he had asthma attacks, episodes or worsening asthma symptoms:	in past 3 months
3) Number of visits to a doctor or other health professional for worsening asthma or an asthma attack:	in past 12 months
4) Number of overnight stays in the hospital because of asthma:	in past 12 months
5) Number of visits to an ER or urgent care center because of asthma:	in past 12 months
6) Number of days of daycare, school, or work missed by this asthmatic because of his/her asthma:	in past 3 months
7) Number of days of school or work missed by other family members because of this asthmatic's asthma:	in past 3 months

Comments:

Asthma management	Status
1) Has any other household member ever been told that smoking in the home affects asthma?	○ Y ○ N ○ U
2) Does s/he have a primary medical care provider?	○ Y ○ N ○ U
3) Does s/he have health insurance?	○ Y ○ N ○ U
4) Does s/he have medicine prescribed by a doctor for "quick relief"? *	○ Y ○ N ○ U
4a) If yes, how many times in the past week did s/he take his/her "quick relief" medicine?	
5) Does s/he have medicine prescribed by a doctor for controlling his/her asthma? *	○ Y ○ N ○ U
5a) If yes, did s/he take the "controller" medication every day in the past week?	○ Y ○ N ○ U
6) Does s/he feel that their asthma is well controlled?	○ Y ○ N ○ U
7) Does s/he use a peak flow meter?	○ Y ○ N ○ U
8) Does s/he have a current written asthma management (or action) plan?	○ Y ○ N ○ U
9) Does s/he (or parent of her/him) know the early warning signs of worsening asthma?	○ Y ○ N ○ U
10) Does s/he know what to do if his/her asthma gets worse?	○ Y ○ N ○ U
11) Does s/he know the triggers that make his/her asthma worse?	○ Y ○ N ○ U
12) Does s/he know what to do to get rid of or avoid asthma triggers?	○ Y ○ N ○ U

Asthma education, products, and referrals provided	Given	Evidence
1) Verbal and written information:		
a) About asthma	○	○
b) About asthma triggers	○	○
c) About smoking & asthma triggers	○	○
2) Hypoallergenic pillow covers	○	○
3) Hypoallergenic mattress covers	○	○
4) Blank asthma management (or action) plan form	○	○
5) Referral for asthma services or resources	○	○
6) Referral for primary care provider	○	○
7) Referral for health insurance coverage	○	○
8) Other (specify in Comments)	○	○

* For help in explaining asthma attacks, quick relief and controller medicines, or written asthma management plan, refer to the Asthma Information Sheet.