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

Asthma Disease Management Assessment

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member 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 condition, 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 ❑ 1-2 times a month ❑ Never

2. How often do you experience wheezing?
(check one) ❑ Daily ❑ 1-2 times a week ❑ 1-2 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 ❑ 1-2 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 ❑ 1-2 times a month ❑ Never

9. What doctor takes care of your Asthma?
(check all that apply) ❑ Primary Care Physician ❑ Allergist ❑ Pulmonologist

10. 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

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Asthma Disease Management Assessment *(continued)*

11. 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

12. 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

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

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

15. Do you use tobacco (smoke, chew, snuff, vape or in any other form)? ❑ Yes ❑ No

16. Does someone in your household smoke/vape? ❑ Yes ❑ No

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

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

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

20. What is your living situation today? (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

21. Within the past 12 months, have you worried that your food would run out before you got money to buy more?
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

22. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No