Green Housing Study

Appendix D8 -6-and 12-month follow-up (Child 7-12 with asthma)

Form Approved OMB No. **0920-XXXX**

Child's ID#	
Household ID#	

Green Housing Study



6 and 12-month Follow-up Questionnaire (Children 7-12 with asthma)

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Casan I	I	`~_ d									ID#	
	Housing S n follow-		7-12 with	asthi	ma)					Ш	ID#	
										Hou	se ID#	_
Interv	iewer I	nitials _	· · · · · · · · · · · · · · · · · · ·		Dat	e:		-				
1.	Obsei	vation	point (C	ircle	e One)	:						
,			ow-up (po low-up (p			,						
2.		-	2	, 1. (2. F	Childca	Idcare? are facility residence			Yes		No	
Heal	th Ca	re Acc	cess									
3.		ild's na		rent	ly cove		kind		th insu		or some other	
	If YES	s, then	ask:			Yes		No		Don't	KNOW	
	3.1		e circle employ Medica or a dis TRICAI Indian I	one er d id o abil RE, Hea re, f	e) or unio or any (ity VA, or lth Ser for pec	government r other milita	ough t-assi ary he rtain	yoursel stance ealth ca disabilit	f or an plan fo re ies	other f or those	amily member e with low income e plan	∋s
4. Do	you h	Probe	if answe	er is	NO: "		re tha	an one,	or is tl	here no	care provider? o person who you	J
		1. 2. 3. 4.	Yes, or More th No Don't ki	nan	one							
Asth	ıma H	istory	,									
	ring the	past 3	months	, ha	ıs [Chi	ld's name] l	nad a	ın episo	de of a	asthma	a or an asthma	

Yes

No

Don't know

Green Housing Study				ID#	
6-month follow-up (Child 7-12 with asthma)			Ho	use ID#	
If NO , then SKIP to Question 14, "regular schedule If YES , how many asthma episodes or attacks?	e of med	icine"			
5.1 Number of times					
6. During the past 3 months, did [Child's name] have because of asthma?	ve an em	ergen	cy or ur(gent care vi	sit
If NO , Skip to Question #8	Yes		No		
If YES , did [Child's name] visit the following?					
6.1 Emergency department6.2 Urgent care center6.3 Emergency visit to doctor's office	Y Y Y	N N N		Number of Number of Number of	of visits
If child went to Emergency department (6.1 is one	or more	visits),	then as	k:	
6.4 Did [Child's name] travel by ambulance	ce?			Yes	No
If YES , how many times?				163	INO
6.4.1 Number of times					
7. During the past 3 months, has [Child's name] state considering the emergency department) because of	•		pital ove	ernight (NO	Т
If YES , how many different times was [Child's name	Yes e] admitt	ed to t	No he hosp:	ital?	
7.1 Number of visits					
(If # of visits equals 1, then min = max)					
7.2 Minimum number of days in hospital					

7.3

7.4

Maximum number of days in hospital

Total number of days in hospital

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Child's ID# _____

Household ID# _____

8. Du	ring the past 3 months, was [Child's name] una Yes No	ble to attend s	chool beca	ause of asthma
If YES	S , then ask: How many days did [Child's name]	miss school?		
	8.1.1 Number of days [Child's name] m [Include only days school was			
8.2	Did this occur in the past 2 weeks?		Yes	No
	If YES , how many times?			
	8.2.1 Number of days [Child's name] m [Include only days school was			
	ring the past 3 months, were YOU unable to att vities because of [Child's name] asthma?	end work or ca	arry out yo No	ur usual
If YES	S , then ask	165	INO	
9.1	Total number of days (use your best gu	uess)		
	9.1.1 Of these, how many work	days did you ı	miss?	
9.2	Did this occur in the past 2 weeks?		Yes	No
If YES	S , then ask 9.2.1 Number of days you misse	d <u>work</u> (if app	licable)	
	9.2.2 Number of days you misse	d <u>other activiti</u> e	<u>es</u>	
10. In	the past 3 months, did [Child's name] wake up	at night becau	use of asth Yes	ıma? No
If YES	S , then ask		163	NO
10.1	Number of nights (use your best gues	ss)		
10.2	Did this occur in the past 2 weeks?	Yes	No	0
	If YES , then ask			
	10.2.1 Number of nights			

	een Housing	Study -up (Child 7-12 with asthma)	Child	's ID#		
				old ID#_		
episo	ode or atta	last 3 months, did [Child's name] take medication when ick? e following:	he/sh	e had a Y	an asth N	ma DK
	L.1 Pleas	se tell me which medicines rviewer: Place a mark in the "Emergency" column next	to eac	h ident	ified m	edicine on
	the m	ned sheet on the last two pages of this questionnaire)				
11	L.2 Did th	nis occur in the past 2 weeks?	Υ	N	DK	
12. Durin Y N	•	3 months, did [Child's name] take prescription asthma r	nedica	itions b	y inhal	er?
	-	ask <u>all</u> of the following:				
12	2.1 How lo	ng did [Child's name] take them? 1. ≤ 1 month				
		2. 2 months				
		3. 3 months				
12		se tell me which medicines	ماه : ماه	.atifia al	al: a:	
	•	rviewer: Place a mark in the "Inhaler" column next to ea sheet on the last two pages of this questionnaire)	ich ide	munea	meaici	ne on the
12		se tell me how many canisters were used up in the past	3 mon	iths		
	(Inter	rviewer: Enter number next to each identified medicine			heet o	n the last two
1.0		s of this questionnaire)	سمام مام	ممالة منا		al.a0
12	2.4 Did [0	Child's name] take prescription asthma medications by i	nnaier Y	In the	past 2 DK	weeks?
	ng the last his/her as	3 months, has [Child's name] taken any prescription methma?	edicine Y	in <u>pill</u> N	or <u>syru</u> DK	<u>p</u> form
16.7	VEO (b	and the Caller Con				
IT '	YES, then	ask the following:				
	(Inter	Please tell me which medicines rviewer: Place a mark in the "Pill/Syrup" column next to sheet on the last two pages of this questionnaire)	each .	identifi	ed med	licine on the
		Did this occur in the past 2 weeks?	Υ	N	DK	
	ng the last :/her asthm	3 months, did [Child's name] take any medicine on a rena?	gular s Y	schedu N	le ever	yday for
If `	YES , then	ask the following:				
	14.1	What was the medication?				
	•	rviewer: Place a mark in the "Regular Schedule" columi			h identi	fied
		cine on the med sheet on the last two pages of this ques		•	DI	
	14.2	Did this occur in the past 2 weeks?	Υ	Ν	DK	

15. During the past 3 months, did [Child's name] have any of these conditions?

	en Housing Study onth follow-up (Child 7-12 with asthma)			Ch	ild's ID#		
	- '				ehold ID# _		
(If Y	'ES to any of the following, enter number of e	episodes in spac	ce provi	ded)	Numbe	er	
	5.1 Flu or cold refined by at least 3 of the following: feverish, stuffy/runn (If YES, then ask)	Y y nose, cough, sore	N throat, b	DK ody aches or tired	ness, for mo	 re than 24 h	iours)
	15.1.1 During these illness episod	les, did [Child Y	l's nan N	ne] asthma (DK	get worse	e?	
	15.1.2 Did [Child's name] receive medicine called Relenza® or zana			-	_	or an in	haled
		Υ	N	DK			
	15.1.3 Was [Child's name] prescri	ibed antibiotio	cs?	Υ	N	DK	
	5.2 Pneumonia 5.3 Bronchitis	Y Y	N N	DK DK			
1!	Enter frequency by circling one choice 5.4 Sneezing, runny/stuffed nose (<u>wit</u>	thout a cold)					
1	5.5 Wheezing 5.6 Cough (<u>without a cold</u>) 5.7 Shortness of breath		Never Never Never	Once/Twice Once/Twice Once/Twice Once/Twice	Monthly Monthly Monthly Monthly	Weekly Weekly Weekly Weekly	Daily Daily Daily Daily
16. vea		not (<i>probe: or</i>	seasc	onal flu vacc	ine?) dur	ing the	past
,				Υ	N	DK	

Child's ID# _	
Household ID#	

Emergency/rescue	Inhaler/ nebulizer	Pill/Syrup	Regular (Daily-use) schedule	# Canisters used in last 3 months	Visual Confirmation		Emergency/rescue	Inhaler/ nebulizer	Pill/Syrup	Regular (Daily-use) schedule	# Canisters used in last 3 months	Visual Confirmation	
						Accolate							Nedocromil
						Acetaminophen							Pediapred
						Advair							Prednisolone
						Advil							Prednisone
						Aerobid							Proventil
						Aerolate							Pirbuterol
						Aerospan HFA							Primatene Mist
						Albuterol							Pro-Air HFA
						Allegra							Proventil
						Alupent							Pulmicort Turbuhaler
						Asmanex							QVAR
						Atrovent							Respid
						Azmacort							Robitussin
						Beclomethasone							Salbutamol
						dipropionate							
						Beclovent							Salmeterol
						Bitolterol							Serevent
						Brethaire							Singulair
						Brethine							Slo-phyllin
						Budesonide							Symbicort
						Choledyl							Terbutaline
						Claritin							Theo-24
						Combivent							Theochron
						Cromolyn							Theoclear
						Deltasone							Theo-Dur

Child's ID#	٠.		
	11	11	1#

Household ID#_

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Emergency/rescue	Inhaler/ nebulizer	Pill/Syrup	Regular (Daily-use) schedule	# Canisters used in last 3 months	Visual Confirmation		Emergency/rescue	Inhaler/ nebulizer	Pill/Syrup	Regular (Daily-use) schedule	# Canisters used in last 3 months	Visual Confirmation	
						Elixophyllin							Theophylline
						Flovent							Theospan
						Flovent Rotadisk							Tilade
						Flunisolide							Tornalate
						Fluticasone							T-Phyl
						Foradil							Triamcinolone acetonide
						Formoterol							Tylenol
						Ibuprophen							Uniphyl
						Intal							Vanceril
						Ipratropium Bromide							Ventolin
						Levalbuterol tartate							Volomax
						Loratidine							Xolair
						Maxair							Xopenex HFA
						Medrol							Zafirlukast
						Metaprel							Zileuton
						Metaproteronol							Zyflo Filmtab
						Methylpredinisolone							Zyrtec
						Montelukast							Other:
						Mometasonefuroate							Other:
						Mucinex							Other:
		-				·							