

Child's ID# \_\_\_\_\_

Household ID# \_\_\_\_\_

## Green Housing Study



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

*Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0906)*

Interviewer Initials \_\_\_\_\_ Date: \_\_\_\_\_

1. Observation point (Circle One):
  - a) 6-month follow-up (post-remediation)
  - b) 12-month follow-up (post-remediation)
  
2. Does [Child's name] attend childcare? Yes      No  
*If yes, please specify*
  1. Childcare facility
  2. Private residence
  3. Both

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## Health Care Access

3. Is [Child's name] currently covered by any kind of health insurance or some other health care plan?

Yes                  No                  Don't know

If **YES**, then ask:

- 3.1 Which of the following types of health care insurance is it?

*(Please circle one)*

1. employer or union either through yourself or another family member
2. Medicaid or any government-assistance plan for those with low incomes or a disability
3. TRICARE, VA, or other military health care
4. Indian Health Service
5. Medicare, for people with certain disabilities
6. Any other type of health insurance or health coverage plan
7. Don't know

4. Do you have one person you think of as your personal doctor or health care provider?  
*Probe if answer is NO: "Is there more than one, or is there no person who you think of as your personal doctor or health care provider?"*

1. Yes, only one
2. More than one
3. No
4. Don't know

## Asthma History

5. During the past 3 months, has [Child's name] had an episode of asthma or an asthma attack?

Yes                  No                  Don't know

If **NO**, then SKIP to Question 14, “*regular schedule of medicine*”  
If **YES**, how many asthma episodes or attacks?

5.1 \_\_\_\_\_ Number of times

6. During the past 3 months, did [Child’s name] have an emergency or urgent care visit because of asthma?

Yes                      No

If **NO**, Skip to Question #8

If **YES**, did [Child’s name] visit the following?

6.1 Emergency department	Y	N	_____	Number of visits
6.2 Urgent care center	Y	N	_____	Number of visits
6.3 Emergency visit to doctor’s office	Y	N	_____	Number of visits

*If child went to Emergency department (6.1 is one or more visits), then ask:*

6.4 Did [Child’s name] travel by ambulance?

Yes                      No

If **YES**, how many times?

6.4.1 \_\_\_\_\_ Number of times

7. During the past 3 months, has [Child’s name] stayed in the hospital overnight (NOT considering the emergency department) because of asthma?

Yes                      No

If **YES**, how many different times was [Child’s name] admitted to the hospital?

7.1 \_\_\_\_\_ Number of visits

*(If # of visits equals 1, then min = max)*

7.2 \_\_\_\_\_ Minimum number of days in hospital

7.3 \_\_\_\_\_ Maximum number of days in hospital

7.4 \_\_\_\_\_ Total number of days in hospital

8. During the past 3 months, was [Child's name] unable to attend school because of asthma?  
Yes                      No

If **YES**, then ask: How many days did [Child's name] miss school?

8.1.1 \_\_\_\_\_ Number of days [Child's name] missed school  
**[Include only days school was in session.]**

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] missed school  
**[Include only days school was in session.]**

9. During the past 3 months, were **YOU** unable to attend work or carry out your usual activities because of [Child's name] asthma?

Yes                      No

If **YES**, then ask

9.1 \_\_\_\_\_ Total number of days (*use your best guess*)

9.1.1 \_\_\_\_\_ Of these, how many work days did you miss?

9.2 Did this occur in the past 2 weeks?                      Yes                      No

If **YES**, then ask

9.2.1 \_\_\_\_\_ Number of days you missed work (*if applicable*)

9.2.2 \_\_\_\_\_ Number of days you missed other activities

10. In the past 3 months, did [Child's name] wake up at night because of asthma?

Yes                      No

If **YES**, then ask

10.1 \_\_\_\_\_ Number of nights (*use your best guess*)

10.2 Did this occur in the past 2 weeks?                      Yes                      No

If **YES**, then ask

10.2.1 \_\_\_\_\_ Number of nights

11. During the last 3 months, did [Child's name] take medication when he/she had an asthma episode or attack? Y N DK

If **YES**, then ask the following:

11.1 Please tell me which medicines  
*(Interviewer: Place a mark in the "Emergency" column next to each identified medicine on the med sheet on the last two pages of this questionnaire)*

11.2 Did this occur in the past 2 weeks? Y N DK

12. During the last 3 months, did [Child's name] take prescription asthma medications by inhaler?  
Y N DK

If **YES**, then ask all of the following:

12.1 How long did [Child's name] take them?

1.  $\leq$  1 month

2. 2 months

3. 3 months

12.2 Please tell me which medicines  
*(Interviewer: Place a mark in the "Inhaler" column next to each identified medicine on the med sheet on the last two pages of this questionnaire)*

12.3 Please tell me how many canisters were used up in the past 3 months  
*(Interviewer: Enter number next to each identified medicine on the med sheet on the last two pages of this questionnaire)*

12.4 Did [Child's name] take prescription asthma medications by inhaler in the past 2 weeks?  
Y N DK

13. During the last 3 months, has [Child's name] taken any prescription medicine in pill or syrup form for his/her asthma?  
Y N DK

If **YES**, then ask the following:

13.1 Please tell me which medicines  
*(Interviewer: Place a mark in the "Pill/Syrup" column next to each identified medicine on the med sheet on the last two pages of this questionnaire)*

13.2 Did this occur in the past 2 weeks? Y N DK

14. During the last 3 months, did [Child's name] take any medicine on a regular schedule everyday for his/her asthma?  
Y N DK

If **YES**, then ask the following:

14.1 What was the medication?  
*(Interviewer: Place a mark in the "Regular Schedule" column next to each identified medicine on the med sheet on the last two pages of this questionnaire)*

14.2 Did this occur in the past 2 weeks? Y N DK

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

(If **YES** to any of the following, enter number of episodes in space provided)

15.1 Flu or cold Y N DK Number  
(Defined by at least 3 of the following: feverish, stuffy/runny nose, cough, sore throat, body aches or tiredness, for more than 24 hours)

(If **YES**, then ask)

15.1.1 During these illness episodes, did [Child's name] asthma get worse?

Y N DK

15.1.2 Did [Child's name] receive Tamiflu® or oseltamivir [*o sel TAM i veer*] or an inhaled medicine called Relenza® or zanamivir [*za NA mi veer*] to treat this illness?

Y N DK

15.1.3 Was [Child's name] prescribed antibiotics? Y N DK

15.2 Pneumonia Y N DK \_\_\_\_\_

15.3 Bronchitis Y N DK \_\_\_\_\_

*Enter frequency by circling one choice*

15.4 Sneezing, runny/stuffed nose (***without a cold***)

Never    Once/ Twice    Monthly    Weekly    Daily

15.5 Wheezing

Never    Once/ Twice    Monthly    Weekly    Daily

15.6 Cough (***without a cold***)

Never    Once/ Twice    Monthly    Weekly    Daily

15.7 Shortness of breath

Never    Once/ Twice    Monthly    Weekly    Daily

16. Did [Child's name] receive a flu shot (*probe: or seasonal flu vaccine?*) during the past year?

Y N DK

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				Pedialpred
			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 dipropionate				Salbutamol
			Beclovent				Salmeterol
			Bitolterol				Serevent
			Brethaire				Singular
			Brethine				Slo-phyllin
			Budesonide				Symbicort
			Choledyl				Terbutaline
			Claritin				Theo-24
			Combivent				Theochron
			Cromolyn				Theoclear
			Deltasone				Theo-Dur

