

NOT FOR DISTRIBUTION FOR REVIEW PURPOSES ONLY

ASTHMA PATIENT SURVEY

Asthma is one of the most important health problems in the United States. You can help our office give you the best possible care for your asthma by completing this survey.

We hope you will answer the questions. No one here will know how you answered the questions. And if you choose to not answer, that's okay.

The survey is easy to do. It will take less than ten minutes. You can do it by using the phone or over the Internet.



USE A TOUCH-TONE PHONE

You may want to read the questions and pick your answers before you call.

- Call the toll-free telephone number: **1-800-841-6024**
- Enter the identification number for *Physician's Name Here*
Physician's ID Number Here
- Answer the questions using the telephone key pad. You can have someone help you.



USE THE INTERNET

- Go to www.abim.org/survey
- Select English or Spanish
- Enter the identification number for *Physician's Name Here*
Physician's ID Number Here
- Click on the "Begin Survey" button
- Read the questions and select your answers
- When you finish, click on the "Submit Survey" button

Thank you very much.

1. **How would you rate your overall health?**
 - 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair
 - 5 Poor

2. **How would you describe your current level of fitness?**
 - 1 Really in shape
 - 2 In shape
 - 3 So-so
 - 4 Out of shape
 - 5 Really out of shape

3. **In the past 4 weeks, did you feel that your asthma was well controlled?**
 - 1 Yes
 - 2 No
 - 3 I'm not sure

4. **In the past 4 weeks, did you miss any work, school or normal daily activity (for example, household chores or social engagements) because of your asthma?**
 - 1 Yes
 - 2 No
 - 3 I'm not sure

5. **In the past 4 weeks, did your asthma wake you up at night?**
 - 1 Yes
 - 2 No
 - 3 I'm not sure

6. **In the past 12 months, how many times did you go to the emergency department because of your asthma symptoms?**
 - 1 None
 - 2 One
 - 3 Two or more

7. **Do you have written instructions from your doctor or someone in the practice on what to do if you are having an asthma attack?**
 - 1 Yes
 - 2 No
 - 3 I'm not sure

8. **Do you use an inhaler for quick relief from asthma symptoms?**
 - 1 Yes
 - 2 No
 - 3 I'm not sure

9. **In the past 4 weeks, what was the highest number of puffs in one day you took of this quick-acting inhaler?**
 - 1 0 to 4 puffs
 - 2 5 to 8 puffs
 - 3 9 to 12 puffs
 - 4 Over 12 puffs
 - 5 I do not use an inhaler for quick relief from asthma symptoms

10. **In the past 12 months, has your doctor or someone in the doctor's office observed you use an inhaler to make sure you use it correctly?**
 - 1 Yes
 - 2 No
 - 3 I'm not sure
 - 4 I don't use an inhaler

11. **Has your doctor ever prescribed an asthma inhaler or pill that is NOT used for quick relief, but is used to control your asthma?**
 - 1 Yes
 - 2 No
 - 3 I'm not sure

12. **What best describes how you take this long-term control medicine now?**
- 1 I take it every day
 - 2 Some days I take it, but other days I don't
 - 3 I used to take it, but now I don't
 - 4 I only take it when I have symptoms
 - 5 I never took it
 - 6 My doctor has never prescribed a medicine for long-term asthma control
13. **How is this practice at encouraging you to ask questions and answering them clearly?**
- 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair
 - 5 Poor
14. **Do you and your doctor make decisions together about your asthma treatment?**
- 1 Yes
 - 2 No
 - 3 I'm not sure
15. **How would you rate your asthma care overall?**
- 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair
 - 5 Poor
16. **How is this practice at going over how to take your asthma medications with you?**
- 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair
 - 5 Poor
17. **How is this practice at giving you information about side effects of your medications?**
- 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair
 - 5 Poor
18. **How is this practice at making sure you understand your asthma triggers (the things that make your asthma symptoms worse)?**
- 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair
 - 5 Poor
19. **Do you smoke cigarettes?**
- 1 Yes
 - 2 No
20. **If you smoke, has your doctor advised you to stop?**
- 1 Yes, more than once
 - 2 Yes, once
 - 3 No
 - 4 I'm not sure
 - 5 Not applicable
21. **In the past 12 months, how much of a problem has it been to schedule appointments with this practice?**
- 1 Not a problem
 - 2 A small problem
 - 3 A big problem
 - 4 Not applicable
22. **In the past 12 months, how much of a problem has it been to reach this practice when you have a question or concern?**
- 1 Not a problem
 - 2 A small problem
 - 3 A big problem
 - 4 Not applicable



23. In the past 12 months, how much of a problem has it been to get a prescription refill from this practice?

- 1 Not a problem
- 2 A small problem
- 3 A big problem
- 4 Not applicable

24. Please enter the two-digit number that represents your age.

25. Please enter your gender.

- 1 Male
- 2 Female

Thank you for taking the time to complete this survey.

SAMPLE

This survey is part of a program sponsored by the American Board of Internal Medicine.

Questions 3, 4, 5, 7, 8, 9, 11, 12 and 14 are Copyright© 1997, 1998, 1999, 200, 2001 Merck & Co., Inc. All rights reserved.