Aberdeen Schools Asthma Survey Questionnaire 2014
In what month and year was your child born?  

Which primary school does your child attend?  

Which primary school year is your child in at present?  
For children in a composite class, which year would they be in if there wasn't a composite class?  

Is your child a boy or a girl?  

Was he/she born in Aberdeen?  

What is the post code where your child currently lives?
1. Has your child wheezed or had a whistle in the chest in the **past three years**?

   If YES, did this occur

   Less than once every three months
   Once every three months
   More than once every three months

2. Does a common cold bring on the wheeze?

   If YES, is a cold the only thing which brings on the wheeze?

   If NO, which other things bring on the wheeze?

   Exercise
   Pets
   Cold weather
   House dust
   Other ....................................................................................

3. Has your child had a persistent night cough in the **past three years**?

   If YES, has this occurred

   Less than once in three months?
   Once in every three months?
   More than once in every three months?

4. Has your child had wheezing or whistling in the chest in the **last 12 months**?

   If YES, how many attacks of wheezing has he/she had in the **last 12 months**?

   1-3
   4-12
   More than 12
5. In the **last 12 months**, how often, on average, has your child’s sleep been disturbed due to wheezing?

- Never
- Less than one night per week
- One or more nights per week

6. In the **last 12 months**, has wheezing ever been severe enough to limit your child’s speech to only one or two words at a time between breaths?

7. Has your child ever had

- Asthma?
- Eczema?
- Hay Fever?

8. Is your child currently on any treatment for wheeze or asthma?

   If YES, which treatment (tick all that apply)

   - Clenil /Budesonide (brown inhaler)
   - Flixotide (orange inhaler)
   - Seretide (purple inhaler)
   - Salmeterol (green inhaler)
   - Symbicort (white inhaler with red base)
   - Montelukast (pink chewy tablet)
   - Salbutamol or terbutaline (blue inhaler)
   - Other (please list) .................................................................

9.a. Has mother ever had

   - Asthma?
   - Eczema?
   - Hay Fever?
9.b. Has father ever had

- Asthma?  
- Eczema?  
- Hay Fever?

10. Does anyone living in the same house as your child smoke?

If YES, please go to question 11. If no, please go to question 15.

11. Do any of the following people smoke? (please tick one box for each person)

<table>
<thead>
<tr>
<th></th>
<th>Smokes every day</th>
<th>Smokes sometimes</th>
<th>Does not smoke</th>
<th>Don't know</th>
<th>My child doesn’t have/see this person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s mother</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Child’s father</td>
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<tr>
<td>Stepfather (mother’s partner)</td>
<td></td>
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<tr>
<td>Stepmother (father’s partner)</td>
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<tr>
<td>Other people in the house</td>
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</tr>
</tbody>
</table>

12. How often do the following people smoke in the child’s home (where your child lives all or most of the time)? (please tick one box for each person)

<table>
<thead>
<tr>
<th></th>
<th>Smokes in the home every day</th>
<th>Smokes in the home sometimes</th>
<th>Does not smoke in the home</th>
<th>Don’t know</th>
<th>My child doesn’t have or see this person</th>
</tr>
</thead>
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<tr>
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</tr>
</tbody>
</table>
13. While your child was inside your home yesterday was anyone smoking there?

   My child wasn't at home yesterday
   There was no one smoking there
   Yes someone was smoking there
   Don't know

14. While your child was in a car yesterday was anyone smoking there?

   My child wasn't in a car yesterday
   There was no one smoking there
   Yes someone was smoking there
   Don't know

15. If you are willing to be contacted about future surveys relating to asthma and allergy in children we would be very grateful if you could provide the following information

   Your child’s name ..........................................................................................................
   Your child’s full address ................................................................................................

Thank you for completing this questionnaire.

Please return it to us using the pre-paid envelope.

If you have any questions, please contact
Dr Steve Turner (01224 438475, email s.w.turner@abdn.ac.uk) or
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Child Health, Royal Aberdeen Children’s Hospital