New York City Department of Health and Mental Hygiene
Bureau of Chronic Disease Prevention & Control
Asthma Initiative
Managing Asthma in Daycare Project

Brief Respiratory Questionnaire (BRQ)

Interviewer: _____ **Date of interview:** ____/____/____ **Center:** _____

Child: _____ ____/____/____ _____ _____
First name Last name D.O.B Gender Class

Ethnicity: ☐ Black ☐ Latino ☐ Asian ☐ White ☐ Mixed (specify):_____ ☐ Other (specify):_____

Parent/caregiver: _____
First name Last name

Relationship to child: ☐ Mother ☐ Father ☐ Other family member ☐ Non-family member (specify): _____

1. **<u>In the past 12 months</u>**, has your child experienced wheezing or whistling in the chest, or a cough that lasted more than a week?

   (1) Yes **(2)** No

2. **<u>In the past 12 months</u>**, how many times did your child experience wheezing or whistling in the chest, or a cough that lasted more than a week?

   ____ **Number of times** *(record "0" if none)*

3. **<u>In the past 12 months</u>**, how many nights did your child have trouble sleeping because of wheezing or whistling in the chest, or a cough that lasted more than a week?

   ____ **Number of nights** *(record "0" if none)*

4. I am going to read you the names of some health conditions. For each one, please tell me if a doctor, medical care provider, or clinic **<u>ever</u>** used that name to describe your child's condition.

Asthma	**(1)** Yes	**(2)** No	***If "Yes," give blank AAP***
RAD (Reactive Airway Disease)	**(1)** Yes	**(2)** No	
Bronchitis or bronchiolitis *(bron-kee-oh-lite-iss)*	**(1)** Yes	**(2)** No	
Asthmatic or Wheezy Bronchitis	**(1)** Yes	**(2)** No	
Wheezing	**(1)** Yes	**(2)** No	

5. In **<u>the past 12 months</u>**, has a doctor, medical provider or clinic **<u>prescribed</u>** any medicine, inhaler, nebulizer, or breathing machine treatments for any of these conditions, that is for asthma, reactive airway disease, bronchitis or bronchiolitis, asthmatic or wheezy bronchitis, or wheezing?

   (1) Yes **(2)** No ***If "Yes," give blank AAP***

6. In **<u>the past 12 months</u>**, how many times did your child have an emergency visit to a doctor, clinic or an emergency room for asthma, wheezing, cough, chest tightness, or shortness of breath?

   ____ **Number of times** *(record "0" if none)* ***If 1 or more, give blank AAP***

7. In **<u>the past 12 months</u>**, how many times did your child have to stay overnight in the hospital for asthma wheezing, cough, chest tightness, or shortness of breath?

   ____ **Number of times** *(record "0" if none)* ***If 1 or more, give blank AAP***

8. Is your child **<u>currently</u>** under the care of a doctor, nurse, or clinic for asthma, wheezing, cough, chest tightness, or shortness of breath?

   (1) Yes **(2)** No