

Supplementary Figure 1

<p>A= Activities P=Persistent G=triGGers A= Asthma medications R= Response to therapy</p>	<h2 style="margin: 0;">APGAR PLUS</h2>	<p>P=Asthma Plan L=Lung function U=Use of inhaler S=Steroids</p>
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Please circle your answers:

A 1. In the past 2 weeks, how many times did any breathing problems (such as asthma) interfere with your **ACTIVITIES** or activities you wanted to do?

Never 1 – 2 times 3 or more times

P 2. How many **DAYS** in the past 2 weeks did you have shortness of breath, wheezing, chest tightness, cough or felt you should use your rescue inhaler?

None 1 - 2 DAYS 3 or more DAYS

3. How many **NIGHTS** in the past 2 weeks did you wake up or have trouble sleeping due to coughing, shortness of breath, wheezing, chest tightness or get up to use your rescue medication?

None 1 - 2 NIGHTS 3 or more NIGHTS

G 4. Do you know what makes your breathing problems or asthma worse?

Yes No Unsure

- Please circle things that make your breathing problems or asthma worse:
Cigarettes Smoke Cold Air Colds Exercise Dust Dust Mites
Trees Flowers Cats Dogs Mold Other: _____
- Can you avoid the things that make your breathing problems or asthma worse?
Seldom Sometimes Most of the time

A 5. List or describe medications you've taken for breathing problems or asthma in the past 2 weeks: Remember you may use Nasal, Oral, or Inhaler medications.

Breathing or Asthma Medication	When taken?		Reasons for taking medication:	Reasons for not taking medication:
	<input type="checkbox"/> Daily	<input type="checkbox"/> As needed		
	<input type="checkbox"/> Daily	<input type="checkbox"/> As needed		
	<input type="checkbox"/> Daily	<input type="checkbox"/> As needed		
	<input type="checkbox"/> Daily	<input type="checkbox"/> As needed		

R 6. When I use my breathing or asthma medicines I feel:

Worse No Different A Little Better A Lot Better