



place label here

Name: _____
 UIN: _____
 Date: _____

INITIAL ASTHMA HISTORY

Please circle or check as appropriate:

1. I was diagnosed with asthma at age _____.
 My Mother Father Sister Brother have asthma.

2. I have experienced the following asthma symptoms:
 Cough Shortness of breath Chest tightness Wheezing Limited activity Sputum Production

My symptoms occur with the following frequency:

DAYS WITH SYMPTOMS	NIGHTTIME SYMPTOMS
<input type="checkbox"/> Continual symptoms <input type="checkbox"/> Limited physical activity <input type="checkbox"/> Frequent attacks / flares	<input type="checkbox"/> Frequent
<input type="checkbox"/> Daily symptoms <input type="checkbox"/> Daily use of rescue inhaler <input type="checkbox"/> Attacks / flares affect activity <input type="checkbox"/> Attacks / flares ≥ 2 times a week; may last days	<input type="checkbox"/> ≥ 1 time a week
<input type="checkbox"/> Symptoms ≥ 2 times a week but < 1 time a day <input type="checkbox"/> Attacks / flares may affect activity	<input type="checkbox"/> ≥ 2 times a month
<input type="checkbox"/> Symptoms ≤ 2 times a week <input type="checkbox"/> No symptoms between attacks / flares <input type="checkbox"/> Attacks / flares brief (from a few hours to a few days)	<input type="checkbox"/> ≤ 2 times a month

3. I have / have never been to an emergency room for asthma or respiratory problems.
 I have / have never been hospitalized overnight for asthma or respiratory problems.
 I have / have never been in the Intensive Care Unit or been intubated for asthma.

4. The following cause and/or worsen my asthma symptoms:

- | | | |
|--|--|----------------------------|
| Exercise | Smoke (tobacco/wood) | Viral infections |
| Pollen | Dust / Dust Mites | Mold / Mildew |
| Animals | Environmental factors | Weather changes |
| Foods | Medications | Airborne dusts / chemicals |
| Home Environment | Strong emotional responses (laughing / crying) | |
| Endocrine factors (menses, pregnancy, thyroid condition) | | |
| Other _____ | | |

5. My asthma has interfered or prohibited me from work or school _____ times in the last year.
 I have the following limitations in my activities (sports or strenuous work) due to my asthma:

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INITIAL ASTHMA HISTORY (cont.)

6. I use my rescue inhaler (for example, Albuterol or Ventolin) at the following frequency:

DAYTIME	NIGHTTIME
<input type="checkbox"/> more than 2 times a day	<input type="checkbox"/> more than 3 times a week at night
<input type="checkbox"/> more than 1 time a day	<input type="checkbox"/> more than 1 time a week at night
<input type="checkbox"/> 3-6 times a week (daytime)	<input type="checkbox"/> more than 2 times a month at night
<input type="checkbox"/> less than 2 times a week (daytime)	<input type="checkbox"/> less than 2 times a month at night

I use my rescue inhaler pre-exercise _____ times per day / week / month.

7. In the past, I have used the following medications for asthma:

Long-Term Control Medications	
Albuterol ext. rel.	<input type="checkbox"/> Volmax <input type="checkbox"/> Proventil Repetabs
Beclomethasone	<input type="checkbox"/> Beclovent <input type="checkbox"/> Vanceril <input type="checkbox"/> Vanceril-DS
Budesonide	<input type="checkbox"/> Pulmicort Turbuhaler
Cromolyn sodium	<input type="checkbox"/> Intal
Flunisolide	<input type="checkbox"/> AeroBid, <input type="checkbox"/> AeroBid-M
Fluticasone	<input type="checkbox"/> Flovent
Fluticasone/salmeterol	<input type="checkbox"/> Advair
Montelukast	<input type="checkbox"/> Singular
Nedocromil sodium	<input type="checkbox"/> Tilade
Salmeterol	<input type="checkbox"/> Serevent
Triamcinolone	<input type="checkbox"/> Azmacort
Zafirlukast	<input type="checkbox"/> Accolate
Zileuton	<input type="checkbox"/> Zyflo

Quick-Relief Medications	
Albuterol	<input type="checkbox"/> Airt <input type="checkbox"/> Proventil <input type="checkbox"/> Proventil HFA <input type="checkbox"/> Ventolin <input type="checkbox"/> Ventolin Rotacaps
Bitolterol	<input type="checkbox"/> Tornalate
Ipratropium bromide	<input type="checkbox"/> Atrovent
Methylprednisolone	<input type="checkbox"/> Medrol
Pirbuterol	<input type="checkbox"/> Maxair
Prednisolone	<input type="checkbox"/> Pediapred <input type="checkbox"/> Prelone
Prednisone	<input type="checkbox"/> Prednisone
Terbutaline	<input type="checkbox"/> Brethaire <input type="checkbox"/> Brethine tablet <input type="checkbox"/> Bricanyl tablet

Currently prescribed medications:

I ACTUALLY take them as follows:

8. I own / do not own a peak flow meter.

I own / do not own a hand held home nebulizer.

I use my nebulizer _____ times per day / week / month.

I use the following medicated solution in my nebulizer _____

Student Signature _____ Provider Signature _____

Date _____