

ASTHMA HISTORY FORM

Student's Name: _____ Date of Birth: _____

History Taken by: _____ Date: _____

Parent/Guardian Name: _____

Home Phone: () _____ Work Phone: () _____

Alternate Contact: _____ Phone: () _____

Primary Health Care Provider: _____ Phone: () _____

Address: _____

When was this student's asthma first diagnosed? _____

How many times has this student been seen in the emergency room for asthma in the past year? _____

How many times has this student been hospitalized for asthma in the past year? _____

Has this student ever been admitted to an intensive care unit for asthma? _____

When? _____

How would you rate the severity of this student's asthma?

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate this student missed last year because of asthma? _____

What triggers this student's asthma?

- exercise respiratory infection strong odors or fumes stress
- cigarette smoke wood smoke pollen
- animals (specify): _____
- foods (specify): _____
- carpets indoor dust outdoor dust
- chalk dust temperature changes molds
- other: _____

What does this student do at home to relieve asthma symptoms (check all that apply)?

- breathing exercises rest/relaxation drinks liquids
- takes medications (see below) uses herbal remedies (see below)
- other (please describe): _____

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What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler, etc.)	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What herbal remedies, if any, does this student take for asthma? _____

Does this student use any of the following aids for managing asthma?

- peak flow meter (personal best if known _____)
- holding chamber spacer holding chamber w/mask
- other: _____

Please check special needs related to your child's asthma:

- physical education class recess animals in classroom
- avoidance of certain foods field trips access to water
- transportation to and from school other
- observation of side effects from medications

If you checked any of the above boxes, please describe needs:

Has this student had asthma education? yes no
Would you like information about asthma education for: student self

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____