

NAME: \_\_\_\_\_  
 PID: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 DATE: \_\_\_\_\_

### Asthma History

1. What age were you diagnosed with asthma?	_____ years old
2. When was your last hospitalization or emergency department visit for asthma, if ever?	
3. Have you had to take oral prednisone or another oral steroid for your asthma in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
4. Have you ever used a daily inhaled steroid (e.g. Pulmicort, Symbicort, Flovent, Advair)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes, what was the name of the medication? _____ How long did you use the medication? _____ <input type="checkbox"/> months <input type="checkbox"/> years
5. What activities or routines have you had to limit in the last 12 months because of your asthma?	
6. Have you received a pneumococcal vaccine as an adult?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
7. Do you receive an annual influenza vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
8. Check all of the following conditions that may apply to you:	
<input type="checkbox"/> nasal allergies, year round <input type="checkbox"/> sinus infections <input type="checkbox"/> eczema, allergic skin problem <input type="checkbox"/> smoke _____ packs/day <input type="checkbox"/> nasal allergies, seasonal <input type="checkbox"/> nasal polyps <input type="checkbox"/> gastric reflux (heartburn) <input type="checkbox"/> chronic bronchitis	
9. Are you currently receiving allergy shots treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Asthma Symptoms

I have experienced the following asthma symptoms:	
<input type="checkbox"/> daytime cough <input type="checkbox"/> nighttime cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> chest tightness <input type="checkbox"/> wheezing <input type="checkbox"/> sputum production	
If you have seasonal symptoms, which season(s) are worse for you?	<input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall <input type="checkbox"/> Winter

### Asthma Symptom Control

In the past <b>4 weeks</b> have you had:		
Daytime symptoms more than twice a week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>FOR PROVIDER USE:</b>  Well controlled    None of these  Partly controlled 1-2 of these  Uncontrolled    3-4 of these
Any nighttime waking due to asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rescue inhaler (Albuterol, Ventolin, Xopenex) needed more than twice a week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any activity limitation due to asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

### Asthma Triggers

The following cause and/or worsen my asthma symptoms:		
<input type="checkbox"/> Exercise <input type="checkbox"/> Smoke (tobacco/wood) <input type="checkbox"/> Dust/dust mites <input type="checkbox"/> Foods or food additives <input type="checkbox"/> Weather changes	<input type="checkbox"/> Mold/mildew <input type="checkbox"/> Respiratory infection, colds <input type="checkbox"/> Pollen <input type="checkbox"/> Animals <input type="checkbox"/> Cold air	<input type="checkbox"/> Medications-beta blockers, advil, ibuprofen, aspirin or other nsaid <input type="checkbox"/> Strong odors <input type="checkbox"/> Strong emotional responses or stress (laughing/crying, fear or anger) <input type="checkbox"/> Air pollutants <input type="checkbox"/> Other:

What other questions about your asthma do you have today?

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