campus HEALTH

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?	☐ Yes ☐ No ☐ Unsure
4. Have you ever used a daily inhaled steroid (e.g. Pulmicort, Symbicort, Flovent, Advair)	☐ Yes ☐ No ☐ Unsure If yes, what was the name of the medication? ________________ How long did you use the medication? ______ ☐ months ☐ 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?	☐ Yes ☐ No ☐ Unsure
7. Do you receive an annual influenza vaccine?	☐ Yes ☐ No ☐ Unsure
8. Check all of the following conditions that may apply to you: ☐ nasal allergies, year round ☐ sinus infections ☐ eczema, allergic skin problem ☐ smoke ____ packs/day ☐ nasal allergies, seasonal ☐ nasal polyps ☐ gastric reflux (heartburn) ☐ chronic bronchitis	
9. Are you currently receiving allergy shots treatment?	☐ Yes ☐ No

Asthma Symptoms

I have experienced the following asthma symptoms:
☐ daytime cough ☐ nighttime cough ☐ shortness of breath ☐ chest tightness ☐ wheezing ☐ sputum production

If you have seasonal symptoms, which season(s) are worse for you?	☐ Spring ☐ Summer ☐ Fall ☐ Winter

Asthma Symptom Control

In the past **4 weeks** have you had:

Daytime symptoms more than twice a week?	☐ Yes ☐ No	FOR PROVIDER USE:
Any nighttime waking due to asthma?	☐ Yes ☐ No	Well controlled None of these
Rescue inhaler (Albuterol, Ventolin, Xopenex) needed more than twice a week?	☐ Yes ☐ No	Partly controlled 1-2 of these
Any activity limitation due to asthma?	☐ Yes ☐ No	Uncontrolled 3-4 of these

Asthma Triggers

The following cause and/or worsen my asthma symptoms:

☐ Exercise	☐ Mold/mildew	☐ Medications-beta blockers, advil, ibuprofen, aspirin or other nsaids
☐ Smoke (tobacco/wood)	☐ Respiratory infection, colds	☐ Strong odors
☐ Dust/dust mites	☐ Pollen	☐ Strong emotional responses or stress (laughing/crying, fear or anger)
☐ Foods or food additives	☐ Animals	☐ Air pollutants
☐ Weather changes	☐ Cold air	☐ Other:

What other questions about your asthma do you have today?

____

____