ILLINOIS
McKinley Health Center

*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 |
|---|---|
| ☐ Continual symptoms<br>☐ Limited physical activity<br>☐ Frequent attacks / flares | ☐ Frequent |
| ☐ Daily symptoms<br>☐ Daily use of rescue inhaler<br>☐ Attacks / flares affect activity<br>☐ Attacks / flares ≥ 2 times a week; may last days | ☐ ≥ 1 time a week |
| ☐ Symptoms ≥ 2 times a week but < 1 time a day<br>☐ Attacks / flares may affect activity | ☐ ≥ 2 times a month |
| ☐ Symptoms ≤ 2 times a week<br>☐ No symptoms between attacks / flares<br>☐ Attacks / flares brief (from a few hours to a few days) | ☐ ≤ 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:**
   _____
   _____

**-OVER-**

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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 |
|---|---|
| ☐ more than 2 times a day | ☐ more than 3 times a week at night |
| ☐ more than 1 time a day | ☐ more than 1 time a week at night |
| ☐ 3-6 times a week (daytime) | ☐ more than 2 times a month at night |
| ☐ less than 2 times a week (daytime) | ☐ 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.** | ☐ Volmax<br>Proventil Repetabs |
| **Beclomethasone** | ☐ Beclovent ☐ Vanceril<br>☐ Vanceril-DS |
| **Budesonide** | ☐ Pulmicort Turbuhaler |
| **Cromolyn sodium** | ☐ Intal |
| **Flunisolide** | ☐ AeroBid, ☐ AeroBid-M |
| **Fluticasone** | ☐ Flovent |
| **Fluticasone/salmeterol** | ☐ Advair |
| **Montelukast** | ☐ Singular |
| **Nedocromil sodium** | ☐ Tilade |
| **Salmeterol** | ☐ Serevent |
| **Triamcinolone** | ☐ Azmacort |
| **Zafirlukast** | ☐ Accolate |
| **Zileuton** | ☐ Zyflo |

| Quick-Relief Medications | |
|---|---|
| **Albuterol** | ☐ Airet ☐ Proventil<br>☐ Proventil HFA<br>☐ Ventolin<br>☐ Ventolin Rotacaps |
| **Bitolterol** | ☐ Tornalate |
| **Ipratropium bromide** | ☐ Atrovent |
| **Methylprednisolone** | ☐ Medrol |
| **Pirbuterol** | ☐ Maxair |
| **Prednisolone** | ☐ Pediapred ☐ Prelone |
| **Prednisone** | ☐ Prednisone |
| **Terbutaline** | ☐ Brethaire<br>☐ Brethine tablet<br>☐ 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**_____