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 ☐ Limited physical activity ☐ Frequent attacks / flares	☐ Frequent
☐ Daily symptoms ☐ Daily use of rescue inhaler ☐ Attacks / flares affect activity ☐ Attacks / flares ≥ 2 times a week; may last days	☐ ≥ 1 time a week
☐ Symptoms ≥ 2 times a week but < 1 time a day ☐ Attacks / flares may affect activity	☐ ≥ 2 times a month
☐ Symptoms ≤ 2 times a week ☐ No symptoms between attacks / flares ☐ 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 Proventil Repetabs
Beclomethasone	☐ Beclovent ☐ Vanceril ☐ 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 ☐ Proventil HFA ☐ Ventolin ☐ Ventolin Rotacaps
Bitolterol	☐ Tornalate
Ipratropium bromide	☐ Atrovent
Methylprednisolone	☐ Medrol
Pirbuterol	☐ Maxair
Prednisolone	☐ Pediapred ☐ Prelone
Prednisone	☐ Prednisone
Terbutaline	☐ Brethaire ☐ Brethine tablet ☐ 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_____