Asthma Patient Initial Visit Form

Patient Name: ____________________

Parent/Guardian Name(s): ____________________ Phone Number: __________

History of Previous Evaluations

Has your child ever been told by a medical care provider that he/she has asthma? Yes No

Has he/she ever been evaluated by an allergist or pulmonologist (lung specialist)? Yes No

Ever had allergy testing? Yes No

If yes, name of doctor: ____________________

Asthma Symptoms

Does your child have frequent episodes of…

- COUGHING Yes No
  Average number of episodes per week ________
- ONGOING NIGHTTIME COUGH Yes No
  Average number of episodes per week ________
- AUDIBLE WHEEZING Yes No
  Average number of episodes per week ________
- DIFFICULTY BREATHING/SHORTNESS OF BREATH **WITHOUT** ACTIVITY Yes No
  Average number of episodes per week ________
- DIFFICULTY BREATHING/SHORTNESS OF BREATH **WITH** ACTIVITY
  How many episodes per week ________ Which activities ____________________
- PROLONGED OR EXCESSIVE COUGH WITH COLDS Yes No

Does your child use their rescue (quick relief) medicine more than twice per week, not counting exercise? Yes No

If yes, number of times per week: __________

Last time your child used his/her rescue medicine: __________

How many flare-ups (exacerbations or attacks) of his/her symptoms have occurred in the past 6 months?

☐None ☐1-2 ☐3 or more

How many times in the past 6 months has he/she required steroids(liquid, tablet, or injection) to control symptoms?

☐None ☐1-2 ☐3 or more

Has your child ever been to the emergency room for asthma or breathing problems? Yes No

If yes, how many times in the past year? ________

Has your child ever been diagnosed with pneumonia? Yes No

If yes, how many times I the past year? ________

—Turn Over Please—

If you do not understand any of these questions, please ask your nurse.

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Has your child ever been hospitalized for asthma, pneumonia, bronchitis, RSV, bronchiolitis, or other breathing problems? Yes No

If yes, how many times I the past year? _________

In the past 6 months, has he/she missed school or other activities because of asthma or breathing problems? Yes No

If yes, how many times? _________

Symptom Triggers

Do any of the following trigger your child's symptoms? *(check all that apply)*

☐Household dust

☐Respiratory infections/cold

☐Aspirin

☐Foods

If yes, list foods: ______________________________

☐Exercise

☐Cold air

☐Perfume

☐Pets at home, work, or daycare?

If yes, list pets: ______________________________

☐Pollens or certain seasons of year

☐Fall ☐Winter ☐Spring ☐Summer

☐Emotion

☐Mold

☐Other irritants:

☐Smoke (cigarette, fireplace, wood)

Environmental Smoke Exposure

Does anyone in your home use a wood burning fireplace or stove?	Yes	No
Is your child, child's caregiver, or parent a smoker?	Yes	No
Is your child exposed to tobacco smoke in his/her home or any other home they frequently visit?	Yes	No
Is your child exposed to tobacco smoke at daycare/school/work?	Yes	No
Does anyone use tobacco products in your car?	Yes	N0

Medication Effects:

Does your child experience any of the following side effects from taking your asthma medicines? *(Circle one number in each row*):

	Never	**Sometimes**	**Always**
Sleeping difficulty	1	2	3
Shakiness (tremors)	1	2	3
Rapid heart rate	1	2	3
Headaches	1	2	3
Moodiness/irritability	1	2	3
Hoarseness	1	2	3
Thrush/yeast infections	1	2	3

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