AMERICAN LUNG ASSOCIATION.
Fighting for Air

ASTHMA HISTORY FORM

Student's Name: _____ Date of Birth: _____

History Taken by: _____ Date: _____

Parent/Guardian Name: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Alternate Contact: _____ Phone: ( ) _____

Primary Health Care Provider: _____ Phone: ( ) _____

Address: _____

When was this student's asthma first diagnosed? _____

How many times has this student been seen in the emergency room for asthma in the past year? _____

How many times has this student been hospitalized for asthma in the past year? _____

Has this student ever been admitted to an intensive care unit for asthma? _____
When? _____

How would you rate the severity of this student's asthma?

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate this student missed last year because of asthma? _____

What triggers this student's asthma?

- ❑ exercise
- ❑ respiratory infection
- ❑ strong odors or fumes
- ❑ stress
- ❑ cigarette smoke
- ❑ wood smoke
- ❑ pollen
- ❑ animals (specify): _____
- ❑ foods (specify): _____
- ❑ carpets
- ❑ indoor dust
- ❑ outdoor dust
- ❑ chalk dust
- ❑ temperature changes
- ❑ molds
- ❑ other: _____

What does this student do at home to relieve asthma symptoms (check all that apply)?

- ❑ breathing exercises
- ❑ rest/relaxation
- ❑ drinks liquids
- ❑ takes medications (see below)
- ❑ uses herbal remedies (see below)
- ❑ other (please describe): _____

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What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler, etc.)	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What herbal remedies, if any, does this student take for asthma? _____

_____

Does this student use any of the following aids for managing asthma?

- ❑ peak flow meter (personal best if known _____)
- ❑ holding chamber ❑ spacer ❑ holding chamber w/mask
- ❑ other: _____

Please check special needs related to your child's asthma:

- ❑ physical education class ❑ recess ❑ animals in classroom
- ❑ avoidance of certain foods ❑ field trips ❑ access to water
- ❑ transportation to and from school ❑ other
- ❑ observation of side effects from medications

If you checked any of the above boxes, please describe needs:

_____

_____

Has this student had asthma education? ❑ yes ❑ no
Would you like information about asthma education for: ❑ student ❑ self

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____