## ASTHMA HISTORY FORM

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student’s Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
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<tr>
<td>History Taken by</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
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<tr>
<td>Parent/Guardian Name</td>
<td></td>
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<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Home Phone: ( )</td>
<td>Work Phone: ( )</td>
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<tr>
<td>Alternate Contact: Phone: ( )</td>
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<tr>
<td>Primary Health Care Provider: Phone: ( )</td>
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<tr>
<td>Address</td>
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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?  

(1) not severe   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  
- [ ] cigarette smoke  
- [ ] animals (specify):  
- [ ] foods (specify):  
- [ ] chalk dust  
- [ ] carpets  
- [ ] indoor dust  
- [ ] outdoor dust  
- [ ] temperature changes  
- [ ] pollen  
- [ ] wood smoke  
- [ ] strong odors or fumes  
- [ ] stress  
- [ ] 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):  

AMES: Asthma Management in Educational Settings  
American Lung Association of Washington-02/01
**ASTHMA HISTORY FORM**

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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Amount</th>
<th>Delivery Method (nebulizer, inhaler, etc.)</th>
<th>How Often</th>
</tr>
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<tbody>
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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: ___________