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:

<table>
<thead>
<tr>
<th>DAYS WITH SYMPTOMS</th>
<th>NIGHTTIME SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Continual symptoms</td>
<td>☐ Frequent</td>
</tr>
<tr>
<td>☐ Limited physical activity</td>
<td></td>
</tr>
<tr>
<td>☐ Frequent attacks / flares</td>
<td></td>
</tr>
<tr>
<td>☐ Daily symptoms</td>
<td>☐ ≥ 1 time a week</td>
</tr>
<tr>
<td>☐ Daily use of rescue inhaler</td>
<td></td>
</tr>
<tr>
<td>☐ Attacks / flares affect activity</td>
<td></td>
</tr>
<tr>
<td>☐ Attacks / flares ≥ 2 times a week; may last days</td>
<td></td>
</tr>
<tr>
<td>☐ Symptoms ≥ 2 times a week but &lt; 1 time a day</td>
<td>☐ ≥ 2 times a month</td>
</tr>
<tr>
<td>☐ Attacks / flares may affect activity</td>
<td></td>
</tr>
<tr>
<td>☐ Symptoms ≤ 2 times a week</td>
<td>☐ ≤ 2 times a month</td>
</tr>
<tr>
<td>☐ No symptoms between attacks / flares</td>
<td></td>
</tr>
<tr>
<td>☐ Attacks / flares brief (from a few hours to a few days)</td>
<td></td>
</tr>
</tbody>
</table>

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-
INITIAL ASTHMA HISTORY (cont.)

6. I use my rescue inhaler (for example, Albuterol or Ventolin) at the following frequency:

<table>
<thead>
<tr>
<th>DAYTIME</th>
<th>NIGHTTIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ more than 2 times a day</td>
<td>☐ more than 3 times a week at night</td>
</tr>
<tr>
<td>☐ more than 1 time a day</td>
<td>☐ more than 1 time a week at night</td>
</tr>
<tr>
<td>☐ 3-6 times a week (daytime)</td>
<td>☐ more than 2 times a month at night</td>
</tr>
<tr>
<td>☐ less than 2 times a week (daytime)</td>
<td>☐ less than 2 times a month at night</td>
</tr>
</tbody>
</table>

I use my rescue inhaler pre-exercise _____ times per       day   /   week   /   month.

7. In the past, I have used the following medications for asthma:

<table>
<thead>
<tr>
<th>Long-Term Control Medications</th>
<th>Quick-Relief Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol ext. rel.</td>
<td>Albuterol</td>
</tr>
<tr>
<td>❑ Volmax</td>
<td>❑ Airet</td>
</tr>
<tr>
<td>❑ Proventil Repetabs</td>
<td>❑ Proventil HFA</td>
</tr>
<tr>
<td>Beclomethasone</td>
<td>❑ Ventalin</td>
</tr>
<tr>
<td>❑ Beclovent</td>
<td>❑ Ventolin Rotacaps</td>
</tr>
<tr>
<td>❑ Vanceril</td>
<td></td>
</tr>
<tr>
<td>❑ Vanceril-DS</td>
<td></td>
</tr>
<tr>
<td>Budesonide</td>
<td>❑ Pulmicort Turbuhaler</td>
</tr>
<tr>
<td>Cromolyn sodium</td>
<td>❑ Intal</td>
</tr>
<tr>
<td>Flunisolide</td>
<td>❑ AeroBid, ❑ AeroBid-M</td>
</tr>
<tr>
<td>Fluticasone</td>
<td>❑ Flovent</td>
</tr>
<tr>
<td>Fluticasone/salmeterol</td>
<td>❑ Advair</td>
</tr>
<tr>
<td>Montelukast</td>
<td>❑ Singular</td>
</tr>
<tr>
<td>Nedocromil sodium</td>
<td>❑ Tilade</td>
</tr>
<tr>
<td>Salmeterol</td>
<td>❑ Serevent</td>
</tr>
<tr>
<td>Triamcinolone</td>
<td>❑ Azmacort</td>
</tr>
<tr>
<td>Zafirlukast</td>
<td>❑ Accolate</td>
</tr>
<tr>
<td>Zileuton</td>
<td>❑ Zyflo</td>
</tr>
<tr>
<td></td>
<td>I ACTUALLY take them as follows:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 __________________________

(reviewed 3/3/12)