Information about your A.S.T.H.M.A.

***All patients with asthma (or parents):* Please complete this form and give it to your doctor.**

Patient's Card / Record Number Embossed Here

Name of Patient: _____

Birth date: _____ **Today's Date:** _____

A ACTIVITIES. Since the last visit, has the patient's asthma interfered with being physically active at home or at school (play, physical education) or in other activities?	**Home** [ ] Yes	**School** [ ] Yes	N, N
S SLEEP. Since the last visit, has the patient's sleep been disturbed by having trouble breathing or coughing?	**Home** [ ] Yes		N
T TRIGGERS. Circle triggers (below) that seem to worsen the patient's asthma: Pet animals Feathers Birds Cigarette smoke Perfume Dust Mold Chalk Are triggers present at home/school?	**Home** [ ] Yes	**School** [ ] Yes	N, N
H HAVING EQUIPMENT HANDY.	**Home**	**School**	
(a) What asthma equipment do you have for use at home and school: Inhaler	[ ] Yes	[ ] Yes	Y, Y
Peak flow meter	[ ] Yes	[ ] Yes	Y, Y
Spacer	[ ] Yes	[ ] Yes	Y, Y
(b) Is rescue inhaler readily available for problems (easy access in school office or self-carry for teens)?	[ ] Yes	[ ] Yes	Y, Y
(c) How long does one inhaler last, on average? _____ weeks	____times in 2 weeks	____times in 2 weeks	
(d) During the past 2 weeks, how often did the patient use his/her quick-relief inhaler?			
M MANAGEMENT PLAN. (a) Do you have a written Asthma Management Plan at home? Does school have one?	**Home** [ ] Yes	**School** [ ] Yes	Y, Y
(b) Do you think the written plan you have for home/school is now out-dated?	[ ] Yes	[ ] Yes	Y, Y
A ATTENDANCE. How many school days (or child daycare days) did the patient miss in the past 2 months because of asthma?		**School** _____ days	

Completed by_____ Date_____

Is there new information since the last time you completed this form?

Name of school (or child care site): _____

Name of school nurse or other health representative: _____ [ ] Do not know

Telephone number of school (if known) _____ [ ] Do not know

A form that permits school and health care provider to exchange information must accompany this form.