

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 <input type="checkbox"/> Yes	School <input type="checkbox"/> Yes	N, N
S SLEEP. Since the last visit, has the patient's sleep been disturbed by having trouble breathing or coughing?	Home <input type="checkbox"/> 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 <input type="checkbox"/> Yes	School <input type="checkbox"/> Yes	N, N
H HAVING EQUIPMENT HANDY. (a) What asthma equipment do you have for use at home and school: <div style="float: right; margin-right: 20px;"> Inhaler Peak flow meter Spacer </div> (b) Is rescue inhaler readily available for problems (easy access in school office or self-carry for teens)? (c) How long does one inhaler last, on average? _____ weeks (d) During the <u>past 2 weeks</u> , how often did the patient use his/her quick-relief inhaler?	Home <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes _____ times in 2 weeks	School <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes _____ times in 2 weeks	Y, Y Y, Y Y, Y Y, Y
M MANAGEMENT PLAN. (a) Do you have a written Asthma Management Plan at home? Does school have one? (b) Do you think the written plan you have for home/school is now out-dated?	Home <input type="checkbox"/> Yes <input type="checkbox"/> Yes	School <input type="checkbox"/> Yes <input type="checkbox"/> Yes	Y, Y Y, Y
A ATTENDANCE. How many school days (or child daycare days) did the patient miss in the <u>past 2 months</u> 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.