Pediatric Care Center

Name:

Age/DOB:

1. How much does your child's asthma bother or interrupt him/her during normal activities (playing, running around, and sports)? ☐Never ☐Rarely ☐Sometimes ☐ Often ☐All of the time

2. How many times has your child been had urgent care or hospitalized for asthma in the past year?

   ☐0 times ☐1 time ☐2 times ☐3 times ☐4 times ☐5 or more times

3. a) What triggers your child's asthma? (Check all that apply)

   ☐ Illness (colds) ☐ Smoke Allergies: ☐Cat ☐ Dog ☐ Dust ☐ Mold ☐Pollen

   ☐ Emotions (crying, laughing, stress) ☐ Exercise/physical activity

   ☐ Food: _____ ☐Weather changes ☐ Strong odors/smells

   Other:_____

   b) Does your child have a life threatening allergy or anaphylaxis? ☐ Yes ☐ No

   - If so, does s/he have an epi-pen at school? ☐ Yes ☐ No

4. Characteristics of the home (circle all that apply):

   Carpeting Old home/mold A lot of upholstery/stuffed furniture

   Humidifier Wood-burning stove Stuffed animals in bed

5. Does anyone smoke in the home (tobacco, other inhaled substances that produce fumes) YES / NO

6. How many days of school has your child missed in the past year due to asthma/respiratory problems

_____

7. Describe the symptoms your child typically experiences <u>before or during an</u> asthma episode: (Check all that apply)

   ☐Coughing ☐ Rubbing chin/neck ☐ Clearing the throat
   ☐Trouble breathing ☐ Breathing hard/fast ☐ Feeling tired/weak ☐ Wheezing
   ☐ Runny nose Other_____

8. How well does your child take his/her asthma medications? (Check only one answer)?

   ☐Takes medicine by self ☐Needs help taking medicine ☐Not using medicine now

9. In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?

   ☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not everyday ☐ Everyday

8. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day? ☐ Never ☐ 1-2 days/week

   ☐ 3 or more days/week but not every day ☐ Everyday

10. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing at night while sleeping?

    ☐ Never ☐ 1-2 times ☐ 3 or more times/month ☐ 2 or more times/week

    ☐ Every night

Current Medications: List or attach all medications taken routinely or on an as needed basis.

Medication	Dosage & Directions	Date started
1.		
2.		
3.		
4.		

Past Medications used for Allergy and Asthma (include oral and topical corticosteroids, antihistamines, inhalers and nose sprays)

Medication	Dosage & Directions	How well did it work?	Any side effects?
1.		None Partial Great	
2.		None Partial Great	
3.		None Partial Great	
4.		None Partial Great	

Allergies: include drug allergies, insects, environmental

Allergy	Date	Describe symptoms	Describe treatment required
1.			
2.			
3.			

Hospitalizations or ER visits in the past 5 years?

Reason	Date	Treatment	Admitted? Hospital name?
1.			
2.			
3.			

Family History:

- ☐ Asthma
- ☐ Hay Fever
- ☐ Food Allergy
- ☐ Drug Allergy
- ☐ Eczema
- ☐ Hives
- ☐ Headaches

11. What worries you about your child's asthma?

_____

12. What do you want to accomplish or learn at this visit?

_____

13. What do you expect from treatment?

_____

FOR STAFF USE:

Asthma Classification

Mild Intermittent	Mild persistent	Moderate persistent	Severe persistent	
Peak flow technique	MDI technique	Review Action Plan	Daily meds	Emergency meds