

**THE UNIVERSITY OF TEXAS MEDICAL BRANCH
ASTHMA MEDICAL HISTORY**

DATE _____ **UH#** _____

NAME _____ **AGE** _____

ADDRESS _____

DOCTORS

Pediatician	Office Address	Phone
_____	_____ () _____	_____
_____	_____ () _____	_____

Asthma/Allergy Specialist	Office Address	Phone
_____	_____ () _____	_____
_____	_____ () _____	_____

Other (s) _____ () _____

Would you like us to send reports to these doctors? Circle YES or NO
If yes, please list each person

_____ _____ _____
_____ _____ _____

FAMILY HISTORY

1. Does anyone in the family have:
- A. Asthma
 - B. Bronchitis
 - C. Emphysema
 - D. Allergies
 - E. Sinus problems

ASTHMA HISTORY

1. Of the following early signs of asthma, which would you say you notice first? Circle all that apply.

- A. Cough
- B. Wheezing
- C. Tightness in chest
- D. Shortness of breath
- E. Itchy eyes, circles under eyes or watery eyes
- F. A decrease by 20% of your personal best peak flow

2. How many times has your child had wheezing, cough, difficulty breathing, chest tightness?
_____ time/month, year, week.

3. Does your child have asthma	YES	NO	How many times per week
a) with activity (sports, crying, running, climbing stairs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) at rest	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) at night	<input type="checkbox"/>	<input type="checkbox"/>	_____

If yes, please describe

4. How many days of school did your child miss in the last school year because of a respiratory illness? _____
5. How many times have you had to take your child to the Emergency Room or Acute Care Clinic with asthma in the past year?
ER _____ Acute Care Clinic _____
6. Has your child been in the hospital for asthma? When? Where?

7. Has your child ever been in the Intensive Care Unit? _____ On a ventilator? _____
8. Does your child have, or has ever had:
- | | YES | NO | Describe: |
|------------------------|--------------------------|--------------------------|-----------|
| skin rashes (dry skin) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| heart problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| other health problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

When do you call the doctor or take your child to the doctor or hospital for an asthma attack?

ASTHMA TRIGGERS (Things that bring on asthma attacks)

Please circle only the answers that apply.

1. What are the main triggers for your child's asthma (things that make asthma worse or bring on asthma symptoms). Circle all that apply. Add other not listed if you need to.

Exercise	Infections	Weather Changes	Cold Air
Cleaning Products	Allergies	Cigarette Smoke	Hair Spray
Emotions (crying, laughing, etc.)		Perfumes	Animals
Other _____			

2. Does your child have any allergies? If so, what are they? Circle all that apply.

Mold	Insect Stings	Sunscreen products	Dust
Foods	Cats	Dogs	Horses
Pollens	Mildew	Fireplace, wood stove, or Barbecue pit	
Other _____		Please Describe _____	

3. Have you noticed an increase in symptoms:

A. During certain times of the year?

1. Summer
2. Fall
3. Spring
4. Winter
5. Changes in seasons

B. When weather changes occur:

1. A front comes through
2. Sudden changes from hot to cold or cold to hot
3. Changes from dry to damp or damp to dry

PEAK FLOW METER

Does your child use a peak flow meter at home? YES or NO

Do you have set ranges (or zones) that you use to change therapy? If so, list them here.

ZONES	CHANGES IN THERAPY
Green: _____	_____
Yellow: _____	_____
Red: _____	_____

What are you child's peak flow readings?
Best morning _____ Best evening _____

Is there anything you would like us to know about how your child is dealing with his/her asthma?

Are there any special concerns that you have about your child's asthma or management at school?

MEDICATIONS

List all medications your child takes on a daily basis: (Include by mouth and inhaled)

ORAL (by mouth):	DOSE:	TIMES:	WHEN/LAST DOSE:
_____	_____	_____	_____
_____	_____	_____	_____

INHALED (machine/inhalers):	DOSE	TIMES:	WHEN/LAST DOSE:
_____	_____	_____	_____
_____	_____	_____	_____

List any other "as needed" medicines your child may use and under what conditions he/she uses them:

How do you react an asthma "attack"? _____

Does you child use a spacer attachment with the inhalers?
 YES, what type? _____ NO

Are there any medications that your child is allergic to? If so which one(s)?
Medicine: _____ Reaction: _____
Medicine: _____ Reaction: _____

Is your child currently on allergy shots (immunotherapy/desensitization)?
 YES NO

If yes, please describe _____

Is your child's immunizations up to date? _____

Where were the immunizations received? _____