Patient Name: _____ Date of Birth: _____

Date of Visit: _____

Asthma Evaluation Form (2 pages)

In the past 6 months how many times has....

...the patient been hospitalized overnight for asthma? _____

...the patient been to the Emergency Room for asthma/breathing problems? _____

...the patient had breathing problems requiring prednisone/steroids? _____

...the patient/parent missed school/work? _____

...Do you have a current (within the last year) asthma action plan _____

...Do you have a current (within the last year) school plan or preschool plan _____

Environmental Tobacco Exposure

Does the patient smoke? ☐Yes ☐No

Does anyone at home or at daycare smoke tobacco? ☐Yes ☐No

Environmental Exposure

What type of housing does the patient have?

☐Mobile home ☐Apartment ☐Single Family

☐Multi-family ☐Shelter

What type of heating system is in the home?

☐Central Hot Air ☐Woodburning Stove ☐Kerosene

☐Hot Water ☐Electric ☐Other_____

Patient's housing is over 100 years old ☐Yes ☐No ☐Unknown

Patient's bedroom or playroom is in the basement ☐Yes ☐No ☐Unknown

Patient's blankets and pillow(s) are machine washable ☐Yes ☐No ☐Unknown

Patient has allergy proof covers for mattress, boxspring, pillow ☐Yes ☐No ☐Unknown

Patient has stuffed animals in his/her bedroom ☐Yes ☐No ☐Unknown

Patient has the following in his/her home (please check all that apply)

Carpet ☐Yes ☐No ☐Unknown

Air purifier ☐Yes ☐No ☐Unknown

Humidifier ☐Yes ☐No ☐Unknown

Mold Growth ☐Yes ☐No ☐Unknown

Scatter Rugs ☐Yes ☐No ☐Unknown

Air Conditioner ☐Yes ☐No ☐Unknown

Dehumidifier ☐Yes ☐No ☐Unknown

Fur animals ☐Yes ☐No ☐Unknown

Dogs # ___ Cats #___ Rabbits # ___ Hamsters/gerbils/mice# ___ Horses# ___ Birds# ___

Patient Name: _____ Date of Birth: _____

Date of Visit: _____

Triggers and Exposure (please check all that apply)

Item	Known Trigger	Exposure Present	Comments
Dust Mites	☐	☐	
Pollen	☐	☐	
Mold	☐	☐	
Tobacco Smoke	☐	☐	
Aerosols/strong odors	☐	☐	
Viral Respiratory Infections	☐	☐	
Animal Dander	☐	☐	
Cockroaches	☐	☐	
Exercise	☐	☐	
Seasonal /Weather Changes (cold air)	☐	☐	
Singing/Laughing/Crying	☐	☐	
Medications (ibuprofen)	☐	☐	
Food, Food additives, Preservatives	☐	☐	
Other	☐	☐	

Patient has the following diagnoses in addition to asthma

☐Allergies	☐Runny nose	☐Sinus Infections	☐Eczema
☐Colds	☐RSV	☐Immunodeficiency	☐Heart Disease (use of beta blockers)
☐Ear Infections	☐ADHD	☐Food Allergies	☐Insect Reaction
☐Reflux	☐Depression	☐Hives	☐Bronchitis/Pneumonia
☐Medication allergies	☐Prematurity	☐Diabetes	☐Cystic Fibrosis

☐Other _____

In close relatives, is there a family history of …

☐asthma	☐allergy	☐sinusitis
☐ eczema	☐nasal polyps	☐rhinitis

Vaccines:

Has patient received the flu vaccine this fall/winter? ☐Yes ☐No

Has patient ever had chicken pox or received the chickenpox vaccine? ☐Yes ☐No

Provider Signature: _____ Date: _____