

Office Use Only

- VFC: [ ] MDD/DKC  
 [ ] Native  
 [ ] NO Insurance  
 [ ] Not Eligible

INSURANCE Notes

# Asthma / Breathing Concerns



Child's name:

\_\_\_\_\_

Child's birthday:

\_\_\_\_\_

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- WT: \_\_\_\_\_ lb  
 \_\_\_\_\_ kg  
 Height: \_\_\_\_\_  
 Temp: \_\_\_\_\_  
 BMI: \_\_\_\_\_  
 B/P: \_\_\_\_\_  
 Pulse: \_\_\_\_\_  
 Resp: \_\_\_\_\_  
 Oxygen: \_\_\_\_\_  
 Pain Scale: \_\_\_\_\_

Since your last visit:

- Do you wheeze/cough (circle one)? Less than 2x/wk; More than 2x/wk; Everyday
- Number of nights you woke up with asthma symptoms? \_\_\_\_\_
- Number of days your asthma got in the way of physical/social activities? \_\_\_\_\_
- Number of days you missed school because of asthma? \_\_\_\_\_
- Do you use a rescue/reliever inhaler more than twice a week? \_\_\_\_\_
- Have you been to the EMERGENCY ROOM? \_\_\_\_\_
- Have you been HOSPITALIZED? \_\_\_\_\_

Does your child:

- Use a Peak Flow Meter Yes / No
- Have an Asthma Action Plan Yes / No
- Use a mask or spacer with an inhaler Yes / No
- Have an inhaler at school Yes / No
- Use a nebulizer machine Yes / No

### Other symptoms:

- |                 |                                   |                    |                                   |
|-----------------|-----------------------------------|--------------------|-----------------------------------|
| Fever           | Yes / No. If yes, how long? _____ | Abdominal pain     | Yes / No. If yes, how long? _____ |
| Nasal discharge | Yes / No. If yes, how long? _____ | Decreased appetite | Yes / No. If yes, how long? _____ |
| Earache         | Yes / No. If yes, how long? _____ | Nausea/Vomiting    | Yes / No. If yes, how long? _____ |
| Sore throat     | Yes / No. If yes, how long? _____ | Diarrhea           | Yes / No. If yes, how long? _____ |
| Headache        | Yes / No. If yes, how long? _____ | Rash               | Yes / No. If yes, how long? _____ |

Does your child have any chronic medical problems? Yes / No. If yes, please explain. \_\_\_\_\_

Is your child taking any prescription medications? Yes / No. If yes, explain. \_\_\_\_\_

Is your child taking any over-the-counter medications? Yes / No. If yes, explain. \_\_\_\_\_

Does your child have a medication allergy? Yes / No. What medication/reaction? \_\_\_\_\_

Has your child been admitted to the hospital overnight? Yes / No. If yes, please explain. \_\_\_\_\_

Has your child had any surgeries? Yes / No. If yes, please explain. \_\_\_\_\_

Has your child been around anyone who is sick? Yes / No. Who? \_\_\_\_\_

Does your family have any pets? Yes / No please circle: dog / cat / other \_\_\_\_\_

Does anyone in the family have:

- Asthma Yes / No please circle: father / mother / brother / sister  
 Seasonal allergies Yes / No please circle: father / mother / brother / sister

Does anyone in the family smoke (includes outside of the house)? Yes / No. If yes, who? \_\_\_\_\_

Does your child attend daycare/preschool/school? (please circle) What grade in school? \_\_\_\_\_

Does your child participate in any sports? Yes / No. If yes, which sport(s)? \_\_\_\_\_

This form completed by: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_