Asthma Questionnaire

Child's Name: ________________________________ Birthdate: ________

Has your child been diagnosed by a medical professional as having Asthma? Yes / No When was child diagnosed? _________ Who is the Doctor: __________________________ and Phone Number: ________________________

Has child been in the hospital? Yes /No How many times? ____
When was the last time in the Hospital? _______Has child been in the emergency room? Yes /NO How many times? ______ When was last time? _______________

Is the asthma seasonal? Yes / NO Is it exercise induced? Yes / No
Is it well controlled? Yes / NO What is your current asthma management?

<u>Current</u> <u>Medications:</u>

Does your child take medication at home <u>currently</u> for Asthma/ Yes /No
Is the medicine taken daily? Yes /NO If yes, name medication and when taken:____
____.

Does your child <u>currently</u> take only "Rescue or As Needed Medication for asthma? Yes /NO If yes, list name and when given:
____
____.

Is there anything that you can identify as triggering the child's asthma?
____

Please list Signs & Symptoms of asthma your child has.
____

____.

Will your child need medication for asthma keep at school? Yes /No
(If yes, have Doctor complete permission form for prescribed or over-the-Counter Medication) and do Health care plan for that child.

Parent / Guardian signature:________________________ Date Completed:_______