

Adult Asthma Intake Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Today's Date: _____ Birthdate: _____

Surname: _____ Given Name: _____

Address: _____

Phone Number: _____ Email Address _____

Physician: _____ Tel: _____

Are you under the care of a physician now? ___Y ___N

If yes, for what? _____

Height: _____ Weight: _____

Referred by: _____

In Emergency Notify: _____ Relationship: _____

Asthma History

How long have you had asthma? _____

When and how was your asthma diagnosed?

What seemed to be the initial cause of your asthma?

Asthma Symptoms (please check any of the following symptoms you currently have, or have had in the past)

- | | | |
|---|---|---|
| <input type="checkbox"/> wheezing | <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> sneezing | <input type="checkbox"/> chest tightness | <input type="checkbox"/> low immunity |
| <input type="checkbox"/> snoring | <input type="checkbox"/> throat clearing | <input type="checkbox"/> swollen glands |
| <input type="checkbox"/> itchy eyes/nose | <input type="checkbox"/> trouble lying down | <input type="checkbox"/> low energy |
| <input type="checkbox"/> nasal congestion | <input type="checkbox"/> runny nose | <input type="checkbox"/> other (please specify) |
| <input type="checkbox"/> fever | <input type="checkbox"/> nasal polyps | _____ |

How many days per week/month do you have symptoms during the day?

How many days per week/month do you have symptoms during the night?

How often do you suffer from an acute attack or exacerbation of your symptoms?

Have you ever been hospitalized or needed emergency care for your asthma? If so, how often? _____

Is it getting worse? ___Y ___N

Does it affect your ___sleep ___work/play ___other (please specify) _____

What makes it better? _____

How frequently are you absent from work/school due to your asthma?

Asthma Triggers (please check any of the following asthma triggers that currently {or have had in the past} aggravate your asthma:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> dust | <input type="checkbox"/> mold | <input type="checkbox"/> pets |
| <input type="checkbox"/> pollution | <input type="checkbox"/> food | <input type="checkbox"/> food additives |
| <input type="checkbox"/> exercise | <input type="checkbox"/> laughter | <input type="checkbox"/> stress |
| <input type="checkbox"/> workplace/school | <input type="checkbox"/> menstruation | <input type="checkbox"/> pollen |
| <input type="checkbox"/> colds/viral infection | <input type="checkbox"/> fumes | <input type="checkbox"/> fragrances |
| <input type="checkbox"/> change in temp. | <input type="checkbox"/> smoke | <input type="checkbox"/> other (please specify) |
- _____

Other Current Treatments _____

Family Medical History

Allergic Rhinitis? ___Y ___N

Asthma? ___Y ___N

Eczema? ___Y ___N

Food allergies? ___Y ___N

Other (please specify) _____

Past Medical History (please any medical conditions you currently have, or have had in the past)

Surgeries(list)

Major Trauma (car accident, fall, etc.)

Asthma Medication

Are you currently taking any of the following asthma medications (please include frequency, form of administration and dosage)?

Bronchodilators (quick acting/rescue medication)

-Please check your current medication:

- | | |
|--|---|
| <input type="checkbox"/> Airt® | <input type="checkbox"/> Tomalate® (bitolterol) |
| <input type="checkbox"/> Proventil® | <input type="checkbox"/> Maxair® (pirbuterol) |
| <input type="checkbox"/> Ventolin® | <input type="checkbox"/> Brethaire® (terbutaline) |
| <input type="checkbox"/> Xopenex® (levalbuterol) | |

·dosage/frequency _____

Inhaled Steroids

-Please check your current medication:

- | | |
|--|--|
| <input type="checkbox"/> Beclovent® | <input type="checkbox"/> Qvar® |
| <input type="checkbox"/> Vanceril® (beclomethasone) <input type="checkbox"/> | <input type="checkbox"/> Pulmicort® Respules |
| <input type="checkbox"/> Pulmicort® Turbohaler (budesonide) | <input type="checkbox"/> Aerobid® (flunisolide) |
| <input type="checkbox"/> Flovent® (fluticasone) | <input type="checkbox"/> Azmacort® (triamcinolone) |

·dosage/frequency _____

Long-acting beta-agonists

-Please check your current medication:

- | | |
|---|--|
| <input type="checkbox"/> Serevent® (salmeterol) | <input type="checkbox"/> Foradil® (formoterol) |
|---|--|

·dosage/frequency _____

Theophylline

-Please check your current medication:

- Aerolate®
- Elixophyllin®
- Slo-bid®
- T-Phyl®

- Choledyl®
- Quibron®
- Theocron®
- Uniphyl®

·dosage/frequency _____

Besides asthma medication are you currently on any prescribed medicine? ____Y ____N

Are you currently taking any non-prescribed medicine (for i.e. herbs, vitamins, supplements, etc.)?
____Y ____N

Have you taken antibiotics before? ____Y ____N

If yes, number of times: _____

Excluding the above listed medicine, have you taken any other medicine in the past?

Diet (please complete the sample menu according to an average day)

Morning _____

Noon _____

Evening _____

Snacks (when & what) _____

Occupational Stress (chemical, Physical, psychological):

Exercise:

Habits: (please circle)

Cigarettes Alcohol Soft drinks Coffee Tea

Please describe or elaborate on the following questions:

Pain – _____

Appetite – _____

Thirsty – _____

Energy – _____

Sleep – _____

Abnormal Sweating – _____

Skin and hair problems – _____

Abnormal Swelling- _____

Bowel Movement – _____

Other digestive problems - _____

Urination – _____

Mood – _____

Headaches - _____

Menstruation- _____

PMS (Premenstrual Symptoms)- _____

How often? _____ How long? _____

Symptoms during menstruation? _____

Pregnancies? _____ Births? _____

Signature _____ Date _____

Thank you for taking the time to fill out this form. All information is confidential and will not be released for legal or medical purposes without your consent.

