

Paediatric 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: _____

Name: _____ Parents Name(s): _____

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 | shortness of breath |
| <input type="checkbox"/> sneezing | <input type="checkbox"/> chest tightness | low immunity |
| <input type="checkbox"/> snoring | <input type="checkbox"/> throat clearing | swollen glands |
| <input type="checkbox"/> itchy eyes/nose | <input type="checkbox"/> trouble lying down | low energy |
| <input type="checkbox"/> nasal congestion | <input type="checkbox"/> runny nose | 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) _____

Have you been immunized for the following (please check all that apply)

- diphtheria
- tetanus
- pertussis
- polio
- measles

- rubella
- chicken pox
- mumps
- other (please specify below

Please indicate if there was any side effect from any of the above immunizations

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

- jaundice
- born premature
- low birth weight
- hay fever
- pneumonia
- strep throat
- oral thrush
- acid reflux
- bronchitis
- parents smoke

- allergies
- impetigo
- fever
- measles
- canker sores
- colic
- hives
- RSV/bronchitis
- nosebleed
- conjunctivitis

- tonsillitis
- bedwetting
- eczema
- ADHD
- cold sores
- whooping cough
- ear infections
- sinusitis
- arthritis
- other (please specify)

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:

- Airt®
- Proventil®
- Ventolin®
- Xopenex® (levalbuterol)
- Tornalate® (bitolterol)
- Maxair® (pirbuterol)
- Brethaire® (terbutaline)

·dosage/frequency _____

Inhaled Steroids

-Please check your current medication:

- Beclovent®
- Vanceril® (beclomethasone)
- Pulmicort® Turbohaler (budesonide)
- Flovent® (fluticasone)
- Qvar®
- Pulmicort® Respules
- Aerobid® (flunisolide)
- Azmacort® (triamcinolone)

· dosage/frequency _____

Long-acting beta-agonists

-Please check your current medication:

- Serevent® (salmeterol)
- Foradil® (formoterol)

·dosage/frequency _____

Is your child currently on any prescribed medicine? ____Y ____N

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

Has your child taken antibiotics before? ____Y ____N

If yes, number of times: _____

Excluding the above listed medicine, has your child taken any other medicine in the past?

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

Morning _____

Noon _____

Evening _____

Snacks (when & what) _____

Does your child eat or drink the following (if so how often)?

- | | |
|---|---|
| <input type="checkbox"/> Juice | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Ice cream | <input type="checkbox"/> Cheese |
| <input type="checkbox"/> Peanut butter | <input type="checkbox"/> Breads |
| <input type="checkbox"/> Raw vegetables | <input type="checkbox"/> Sweets and sugar |

Was your child breast fed? ____Y ____N

When and how did you introduce solid food?

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.