Information About Your A.S.T.H.M.A.

Please complete this form and give it to your doctor.

Name: _____ Date of birth: _____ Today's date: _____

		HOME	WORK
ACTIVITIES	Since the last visit, did your asthma stop you from being physically active or doing regular daily activities?	☐ Yes ☐ No	☐ Yes ☐ No
SLEEP	Since the last visit, has your sleep been disturbed by trouble breathing or coughing?	☐ Yes ☐ No	
TRIGGERS	Check any of the following things that make your asthma worst. ☐ Pets ☐ Feathers ☐ Birds ☐ Cigarette Smoke ☐ Perfume ☐ Dust ☐ Mold ☐ Chalk ☐ Colds Are triggers present at home / work?	☐ Yes ☐ No	☐ Yes ☐ No
HANDY EQUIPMENT	a) Do you use an inhaler for asthma? b) Do you use a peak flow meter? c) Do you use a spacer? d) Do you use a nebulizer? e) Do you have a quick-relief inhaler readily available when your asthma gets worse? f) During the **past 2 weeks**, how often did you use a quick-relief inhaler? g) How long does one inhaler last, on average? ____ weeks	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ____ times	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ____ times
MANAGEMENT PLAN	Do you have an Asthma Action Plan?	☐ Yes ☐ No	☐ Yes ☐ No
ATTENDANCE	How many days did you miss work in the **past 2 months** because of asthma?		____ days

Current concerns:
Current medications used for asthma: