Humble Independent School District Health Services

Asthma Health History

Student Name: _____

Student ID: _____ Date of Birth: _____

Parent/Guardian: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

1. Does your child have a diagnosis of an asthma from a healthcare provider: ☐ **No** ☐ **Yes**

Managing physician: _____ Phone: _____

2. History of Current Status:

a. What are your child's triggers:

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Odors/Fumes
- ☐ Vapors _____
- ☐ Foods _____
- ☐ Animals _____
- ☐ Dust
- ☐ Mold
- ☐ Pollen
- ☐ Other: _____

b. Age of student when asthma first diagnosed: _____

c. Date of last asthma episode: _____

c. How often does your child use his/her **rescue** inhaler:

☐ Rarely ☐ Occasionally ☐ Monthly ☐ Weekly

☐ My child does not have a/has not been prescribed a rescue inhaler

d. Symptoms: _____

e. Ever hospitalized due to asthma: ☐ Yes ☐ No

If yes, explain: _____

f. Are the number of episodes: ☐Same ☐Better ☐Worse

3. Trigger and Symptoms:

a. What are the early signs and symptoms of your student's asthma episode? *(Be specific; include things the student might say)* _____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after trigger? Within: _____ secs _____ mins _____ hrs _____ days

d. Please check the symptoms your child has experienced in the past:

General	Abdominal	Throat	Lungs	Heart
☐ Trouble Sleeping caused by coughing, SOB, Wheezing	☐ Nausea	☐ Itching	☐ Shortness of breath	☐ Increase pulse
☐ Frequent Respiratory Infections	☐ Vomiting	☐ Tightness	☐ Repetitive Cough	☐ Loss of Consciousness
☐ Delayed recovery of Bronchitis episodes		☐ Frequent Intermittent Cough	☐ Whistling or Wheezing when exhaling	☐ Chest pain
☐ Limited exercised because of Shortness of Breath		☐ Frequent cough	☐ Chest Congestion	
☐ Fatigue			☐ Chest Tightness	

4. Treatment:

a. How asthma being treated and/or medication student is taking (both daily and rescue)? _____

b. How effective is the student's response to treatment? _____

c. Has there ever been an emergency room visit? ☐ No ☐ Yes, explain: _____

d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: _____

e. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

f. Have you used the treatment or medication? ☐ No ☐ Yes

g. Please describe any side effects or problems your child had in using the suggested treatment: _____

5. Self Care:

a. Is your student able to recognize and monitor their asthma symptoms? ☐ No ☐ Yes

b. Does your student:

1. Know what triggers to avoid……..... ☐ No ☐ Yes
2. Communicate asthma symptoms……..... ☐ No ☐ Yes
3. Tell an adult immediately when symptoms occur…… ☐ No ☐ Yes
4. Wear a medical alert bracelet, necklace, watchband……. ☐ No ☐ Yes
5. Tell peers and adults about the allergy……. ☐ No ☐ Yes

c. Does you student know how to use their emergency medication? ☐ No ☐ Yes

d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Family/Home

a. How do you feel that the whole family is coping with your student's asthma? _____

b. Does your child carry a rescue inhaler in the event of an asthma episode? ☐ No ☐ Yes

c. Has your child ever had to use a rescue inhaler? ☐ No ☐ Yes

d. Do you feel that your child needs assistance in coping with his/her asthma? ☐ No ☐ Yes

7. General Health:

a. How is your child's general health other than having asthma? _____

b. Does your child have other health conditions? _____

c. Please add anything else you would like the school to know about your child's health: _____

_____

8. Notes:

Parent/Guardian Signature: _____ **Date:** _____

Reviewed by: _____ **Campus:** _____ **Date:** _____