



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 asthma from a healthcare provider: No Yes

Managing physician: _____ Phone: _____

2. History of Current Status:

<p>a. What are your child's triggers:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Exercise</td> <td><input type="checkbox"/> Foods _____</td> </tr> <tr> <td><input type="checkbox"/> Respiratory infections</td> <td><input type="checkbox"/> Animals _____</td> </tr> <tr> <td><input type="checkbox"/> Change in temperature</td> <td><input type="checkbox"/> Dust</td> </tr> <tr> <td><input type="checkbox"/> Odors/Fumes</td> <td><input type="checkbox"/> Mold</td> </tr> <tr> <td><input type="checkbox"/> Vapors _____</td> <td><input type="checkbox"/> Pollen</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table> <p>b. Age of student when asthma first diagnosed: _____</p> <p>c. Date of last asthma episode: _____</p>	<input type="checkbox"/> Exercise	<input type="checkbox"/> Foods _____	<input type="checkbox"/> Respiratory infections	<input type="checkbox"/> Animals _____	<input type="checkbox"/> Change in temperature	<input type="checkbox"/> Dust	<input type="checkbox"/> Odors/Fumes	<input type="checkbox"/> Mold	<input type="checkbox"/> Vapors _____	<input type="checkbox"/> Pollen	<input type="checkbox"/> Other: _____		<p>c. How often does your child use his/her rescue inhaler:</p> <p><input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> My child does not have a/has not been prescribed a rescue inhaler</p> <p>d. Symptoms: _____</p> <p>e. Ever hospitalized due to asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____</p> <p>f. Are the number of episodes: <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse</p>
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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
<input type="checkbox"/> Trouble Sleeping caused by coughing, SOB, Wheezing	<input type="checkbox"/> Nausea	<input type="checkbox"/> Itching	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Increase pulse
<input type="checkbox"/> Frequent Respiratory Infections	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Tightness	<input type="checkbox"/> Repetitive Cough	<input type="checkbox"/> Loss of Consciousness
<input type="checkbox"/> Delayed recovery of Bronchitis episodes		<input type="checkbox"/> Frequent Intermittent Cough	<input type="checkbox"/> Whistling or Wheezing when exhaling	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Limited exercised because of Shortness of Breath		<input type="checkbox"/> Frequent cough	<input type="checkbox"/> Chest Congestion	
<input type="checkbox"/> Fatigue			<input type="checkbox"/> Chest Tightness	

4. Treatment:

- a. How is asthma being treated? _____
- b. What medication is the student taking (both daily and rescue)? _____
- c. How effective is the student's response to treatment? _____
- d. Has there ever been an emergency room visit? No Yes, explain: _____
- e. Was the student admitted to the hospital? No Yes, explain: _____
- f. Has your healthcare provider provided you with a prescription for medication? No Yes
- g. Have you used the treatment or medication? No Yes
- h. 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 their asthma..... No Yes
- c. Does your 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: _____