Navigator
For Asthma

Name_____
DOB_____
Sex_____Height_____Weight_____
Date of last office visit?_____

Child History Form

Does your child have any allergies? _____ Food Allergies? _____ Medication allergies? _____

Date of last flu shot? _____ Status of vaccinations? _____

Current medications? _____

Has you child had a(n):

Asthma Diagnosis? ☐ Yes ☐ No Allergy skin test? ☐ Yes ☐ No Spirometry (breathing) test? ☐ Yes ☐ No

Peak flow meter? ☐ Yes ☐ No Does your child currently use a peak flow meter? ☐ Yes ☐ No

Has your child's asthma been better or worse since your last visit? _____

In the past 6 months, has your child: ☐ Been to the emergency department? Number of times _____

☐ Been to the Hospital? Number of times _____ ☐ Been to the ICU? Number of times _____

☐ Taken oral steroids? Which ones? _____ ☐ Missed School? Number of days _____

Type of visit today? ☐ **Acute** ☐ **Follow –up** ☐ **Post-hospital/emergency department**

Has a doctor or nurse ever told you that your child has asthma?	☐ Yes	☐ No	At what age_____
Does your child ever wheeze?	☐ Yes	☐ No	
Does you child ever have shortness of breath?	☐ Yes	☐ No	
Does your child ever have chest tightness?	☐ Yes	☐ No	
Does your child ever have a cough that will not go away?	☐ Yes	☐ No	
Does your child ever cough at night when he or she does not have a cold?	☐ Yes	☐ No	
Does your child ever have breathing problems when the air temp changes?	☐ Yes	☐ No	
Has your child ever needed urgent medical care because of asthma?	☐ Yes	☐ No	
Has your child ever missed school because of asthma symptoms?	☐ Yes	☐ No	
Does your child have trouble exercising?	☐ Yes	☐ No	
Does your child have limitations with activities?	☐ Yes	☐ No	
Do you have family members with asthma or allergies?	☐ Yes	☐ No	

Are your child's asthma symptoms seasonal or all year long?_____

Have you noticed triggers that bring on your child's asthma? ☐ Yes ☐ No

Which triggers? _____

How many days a week does your child take controller medications? _____

Hay many days a week does your child take reliever medications? _____

Number of times per day _____

Has your child ever stopped taking his or her asthma medications? ☐ Yes ☐ No

If yes, why? _____

How may colds has your child had in the past 6 months? _____

Environmental

Are there smokers in your house or in places where your child spends time (eg, day care, school)? ☐ Yes ☐ No

Who and where? _____

Are there animals in your house or in places where you child spends time (eg, daycare, school)? ☐ Yes ☐ No

Type of animals _____ How many? _____ Where do they sleep? _____

Do you have a basement? ☐Yes ☐ No

Do you have carpeting? ☐Yes ☐ No If yes, where? _____

Are any of the following in your child's home or where your child spends time (eg, day care, school)?

☐ Mold ☐ Cockroaches ☐ Mice ☐ Stuffed animals

What kind of cooling and heating system do you have at home? _____