THE COVENANT PREPARATORY SCHOOL

Asthma Health History

Student Name: _____ Grade Level: _____ DOB: _____

1. History of Current Status

a. What are your child's triggers:

❑ Exercise
❑ Respiratory infections
❑ Change in temperature
❑ Odors/Fumes
❑ Vapors _____
❑ Other: _____
_____

❑ Foods _____
❑ Animals _____
❑ Dust
❑ Mold
❑ Pollen

b. Age of students 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

2. 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 exercise because of shortness of breath		❑ Frequent cough	❑ Chest congestion	
❑ Fatigue			❑ Chest tightness	

3. 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: _____