ASTHMA MANAGEMENT  NAME______________________________ DATE __________
Initial Assessment   DOB_______________ID#________________

For use by the clinician to guide the assessment of a child with symptoms suggestive of asthma

HISTORY:
1. Symptoms
   ___ Daytime cough   ___ Daytime wheezing   ___ SOB   ___ Chest tightness   ___ Sputum production
   ___ Nighttime cough   ___ Nighttime wheezing   ___ Interrupted sleep due to symptoms

2. Patterns of Symptoms
   ___ Perennial, seasonal, or both
   ___ Continual, episodic, or both
   ___ Onset, duration, frequency (# of days or nights per week or month)
   ___ Diurnal variations, esp. nocturnal & on awakening in early morning

3. Precipitating and/or aggravating factors
   ___ Viral respiratory infections   ___ Environmental allergens (indoors/outdoors)
   ___ Exercise   ___ Irritants (tobacco smoke, strong odors, chemicals)
   ___ Changes in weather, exposure to cold air   ___ Animal dander or feathers
   ___ Foods, food additives, food preservatives   ___ Emotional expression (fear/anger/crying/laughing)
   ___ Drugs (aspirin, NSAIDs, beta-blockers including eye drops, others)
   ___ Other

4. Development of disease and management/treatment
   Age of onset and diagnosis
   Use of peak flow meter (frequency, current readings)
   Present medications
   Need for oral corticosteroids and frequency of use
   Episodes of unscheduled care:
      Hospitalization
      Emergency Room
      Urgent Care Clinic
   Life-threatening exacerbations:
      Intubation   ICU admission
   Typical exacerbation:  Frequency
      Usual prodromal signs/symptoms
      Usual patterns and management (what works?)
   Number of days missed from school (parents from work) due to asthma symptoms
   Limitations of activity
   Effect on growth, development, school

5. Social history (of the student/family)
   Home environment
   Members of household
   Family members with health problems
   Smoking in the home
   Substance abuse
   Social support/network
   Education level (parents)   Employment
   Health insurance coverage
   Economic impact of asthma on the family
   Pt/Family perception of asthma

Signature (staff)___________________________________ Date________________
Referral: ___________________________________________