

## ASTHMA FORM

APPLICANT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

1. APPROXIMATE AGE AT ONSET: \_\_\_\_\_ DATE OF LAST ATTACK: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. USUAL FREQUENCY OF ATTACKS (PER YEAR): \_\_\_\_\_

3. BRIEFLY DESCRIBE USUAL ATTACK: \_\_\_\_\_  
 \_\_\_\_\_

LIST DATES OF ANY EPISODES OF STATUS ASTHMATICUS: \_\_\_\_\_

4. LAST ASTHMA HOSPITALIZATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

NUMBER OF ASTHMA HOSPITALIZATIONS IN THE LAST 5 YEARS : \_\_\_\_\_

LAST VISIT TO AN EMERGENCY ROOM (OR SIMILAR EMERGENCY TREATMENT FACILITY): \_\_\_\_/\_\_\_\_/\_\_\_\_

NUMBER OF EMERGENCY ROOM VISITS (OR SIMILAR) IN THE PAST 2 YEARS (EXCLUDING HOSPITALIZATIONS): \_\_\_\_\_

HAS TREATMENT EVER INCLUDED INTUBATION?: \_\_\_\_\_ IF YES, HOW MANY TIMES?: \_\_\_\_\_

5. DESCRIBE RESTRICTIONS OF YOUR ACTIVITIES BECAUSE OF ASTHMA (INCLUDING LOST WORK / SCHOOL TIME): \_\_\_\_\_  
 \_\_\_\_\_

6. DO YOU HAVE A CHRONIC COUGH?: \_\_\_\_\_ IF SO, DESCRIBE (i.e. FREQUENCY, CIRCUMSTANCES, PRODUCTION, etc.): \_\_\_\_\_  
 \_\_\_\_\_

7. DO YOU OR HAVE YOU EVER SMOKED?: \_\_\_\_\_ IF STOPPED, LAST TIME SMOKED?: \_\_\_\_\_

8. ARE YOU SHORT OF BREATH WHEN YOU ARE NOT HAVING AN ASTHMA EPISODE?: \_\_\_\_\_

9. DO YOU OR HAVE YOU EVER TAKEN ALLERGY SHOTS FOR DESENSITIZATION?: \_\_\_\_\_

10. HAVE PULMONARY FUNCTION TESTS BEEN PERFORMED?: \_\_\_\_\_ IF "YES", PLEASE ATTACH LATEST REPORT.

### MEDICATION

LIST ALL MEDICATIONS YOU ARE CURRENTLY USING AND INDICATE DOSE AND FREQUENCY. CHECK ONE FOR EACH MEDICATION.

MEDICATION	DOSE	SEVERAL TIMES A DAY	AT LEAST ONCE DAILY	AT LEAST ONCE WEEKLY	AT LEAST ONCE MONTHLY