To be filled out by Health Center staff

Age: ____________________ VS: ____________________

LMP: ____________________ Allergies: ____________________

Smoking: ____________________ Meds: ____________________

How old were you when you first started experiencing asthma symptoms? ____________________

In your immediate family (mother, father, siblings) is there any history of: ☐ Allergies ☐ Wheezing ☐ Eczema

Have you ever been hospitalized for your asthma? ☐ Yes ☐ No

Have you been to the emergency room for asthma? ☐ Yes ☐ No

How often does your asthma interfere with daily activities (work or school)? ____________________

How many times a week are you using an inhaler for quick relief? ____________________

How often do you wake up at night with asthma symptoms? ____________________

How many canisters of quick relief medication (Albuterol, Maxair, Proventil, Ventolin) do you use:

per month? ____________ per year? ____________

Do you have a peak flow meter? ☐ Yes ☐ No

Do you keep track of your peak flow on a regular basis? ☐ Yes ☐ No

Do you have a nebulizer? ☐ Yes ☐ No

Please check all of the following that trigger your asthma or make it worse.

- ☐ Air polution
- ☐ Animals
- ☐ Stuffed animals
- ☐ Cold air, air conditioning
- ☐ Weather changes
- ☐ Cockroaches
- ☐ Upper respiratory infections/colds
- ☐ Dust, dust mites
- ☐ Exercise, using stairs or other physical activities
- ☐ Food or drinks
- ☐ High humidity
- ☐ Medications
- ☐ Mold, mildew
- ☐ Perfume, body deodorants, or strong chemical smells
- ☐ Pollen
- ☐ Stress, strong emotional responses
- ☐ Smoke
- ☐ Other

Clinician signature ______________________________ Date ______________

ID# ____________________ Name ______________________________

Western Michigan University
Sindecuse Health Center

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ASTHMA PROGRESS NOTE - INITIAL

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