Homer Medical Center/SPH
Pediatric Asthma Intake Form

NAME:_____AGE:_____BIRTHDAY:_____

PRIMARY/REFERRNG PROVIDER:_____

What would you like addressed at this clinic visit?

_____

_____

_____

What is your child's current asthma care plan?

_____

_____

_____

Does your child experience, or has experienced any of the following?

YES/NO	YES/NO	YES/NO
___ ___ Nasal congestion	___ ___ Persistent cough	___ ___ Itchy/watery eyes
___ ___ Runny nose	___ ___ Barking cough	___ ___ Red/swollen eyes
___ ___ Sneezing	___ ___ Night cough	___ ___ Dark circles under eyes
___ ___ Frequent colds	___ ___ Wheezing	___ ___ Heartburn
___ ___ Loss of sense of smell	___ ___ Wheezing w/ exercise	___ ___ Excessive gas

YES/NO	YES/NO	YES/NO
___ ___ Colored nasal discharge	___ ___ Shortness of breath	___ ___ Frequent belly aches
___ ___ Itchy nose	___ ___ Noisy breathing	___ ___ Frequent vomiting
___ ___ Drainage down the throat	___ ___ Bronchitis	___ ___ Poor weight gain
___ ___ Frequent throat clearing	___ ___ Bronchiolitis	___ ___ Poor growth
___ ___ Colored nasal discharge	___ ___ Pneumonia	___ ___ Slow development
___ ___ Hoarseness	___ ___ Apnea(stops breathing)	___ ___ Skin rashes
___ ___ Bad breath	___ ___ Frequent headaches	___ ___ Eczema/Atopic Derm.
___ ___ Sinus infections	___ ___ Frequent ear infections	___ ___ Food allergy

___ ___ Has your child been seen in the Emergency Room for asthma?

If yes, how many times in the past year?_____

When was the most recent visit?_____

___ ___ Has your child received oral steroids (ex. Prednisone) for asthma in the past year?_____

If yes, how many times in the past year?_____

When was the last course?_____

___ ___ Has your child ever spent a night in the hospital for asthma?

If yes, how many times in the past year? _____

When was the last hospitalization?_____

___ ___ Has your child ever been admitted to the ICU or needed a breathing tube for asthma?

___ ___ Has your child been tested for allergies? Any positive results?_____

___ ___ Has your child received hyposensitization (immunotherapy) injections?

SCHOOL/DAYCARE

Name of School or Childcare_____ Address_____

Phone number_____ School Nurse_____

Has your child missed school related to asthma?_____ About how many days a month?_____

Does your child participate in PE classes?_____

Does your child participate in extracurricular sports? _____ Which ones?_____

Does your child take medicines at school?_____ If yes, what medication?_____

Does your child receive supervision taking medication in school? _____ If yes, by whom?_____

Is your child able to keep inhalers with him/her?____

Do you and the school/daycare have a plan for an asthma episode (attack) at school?____

If yes, please describe_____

Can you identify any specific trigger(s) that makes your child's asthma worse?

☐ Cats	☐ Dogs	☐ Grass	☐ Pets	☐ Stress
☐ Cold air	☐ Dust	☐ Heat	☐ Perfumes	☐ Cigarette smoke
☐ Chemicals	☐ Food	☐ Mold	☐ Scents	☐ Other_____

SOCIAL HISTORY

With whom does your child primarily live: _____

Does your child live in multiple households:_____

Describe the household(s) where your child lives (eg, house, apartment):_____

How long has your child lived in this home?_____

What type of heating system does the home have?

☐ Boiler	☐ Space heater	☐ Other
☐ Forced air	☐ Fireplace	
☐ Wood burning stove	☐ Radiant Flooring	

What type of flooring is in the home?

☐ Wall to wall carpet	☐ Linoleum
☐ Hardwood	Other_____

What type of flooring is in your child's bedroom?_____

Does your home have a:

☐ Air purifier	☐ Humidifier in child's bedroom
☐ Dehumidifier	☐ HRV Unit

Are there any pets in the home?: YES NO If yes, list:_____

Are there problems with pests (eg. mice, cockroaches?_____

Are you (or your child's parents/guardians) employed:___ Occupation?_____

Has your house/ apartment ever had water damage?_____

Do you see or smell mold/mildew in your home?_____
If yes, where:_____

Are there any smokers in the home: YES NO

If so, where do they smoke?_____

Does your child follow a special diet: YES NO

If so, what type_____

Has your child traveled internationally:

If yes, when/where:_____

MEDICATIONS

Please list any allergies your child has to medications?_____
What type of reaction?_____
List any medications your child is taking. Please include supplements, and vitamins.

Medication name	**Dosage (strength & Times/day)**	**How long has it been taken?**	**Does it help? A lot**	**Some**	**None**
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐

Natural or Alternative Therapies (chiropractic, acupuncture, magnets, massage, etc)

_____

_____

PAST MEDICAL HISTORY Has your child had any of the following?

ADD/ADHD	Bronchiolitis	Broken bones	Prematurity
Abdominal Pain	Bronchitis	GE Reflux	Kidney Infection
Acne	Chickenpox	Headaches	Recurrent Ear Infections
Allergic Rhinitis	Concussion	Hearing Problems	Seizure Disorder
Allergies	Congenital Heart Disease	Heart Murmur	Seizures Febrile
Anemia	Constipation	Menstrual Problems	Sleep Problems
Asthma	Diabetes	Migraines	Urinary Reflux
Bleeding Disorder	Eczema	Pneumonia	Urinary Tract Infections

PAST SURGICAL HISTORY

DATE	SURGERY	SURGEON

FAMILY MEDICAL HISTORY Have any family members had the following conditions?
M=Mother **F**=Father **S**=Sibling **MG**=Maternal Grandparent **PG**= Paternal Grandparent **U/A**= Uncle/Aunt

CONDITION	M	F	S	M	P	U	CONDITION	M	F	S	M	P	U	CONDITION	M	F	S	M	P	U
ADHD							Developmental Delays							Kidney Abnormalities						
Allergies							Diabetes							Migraines						
Asthma							Eczema/ Psoriasis							Obesity						
Autoimmune Disorders							Gastrointestinal Disorders IBS/IBD							Psychiatric Disorders						
Autism							Genetic Disorder							Rheumatologic Disease						
Birth Defects							Heart Disease							Scoliosis						
Blood Disorder							Hip Problems							Seizure Disorder						
Cancer							High Blood Pressure							Sudden Infant Death						
Deafness							High Cholesterol							Thyroid Disease						
Depression							Learning Disability							Other:						