



Asthma History Questionnaire

Name: _____ Banner # _____

Permanent Address: _____

Home Telephone #: _____ Date of Birth: _____

Family Physician: _____ Physician Phone # _____

Triggers (Please Circle): Weather changes Colds Exercise Pets Smoke
Stress Grass Weeds Pollen

Other: _____

HISTORY: 1) Hospitalization: Where and date(s) _____

2) Last asthma attack _____

Inhalers: Yes or No

If yes, names of inhalers used: _____

3) Personal Peak flow meter? Yes or No

a) Spacer? Yes or No b) Nebulizer? Yes or No

Best Personal Flow number(s): _____

COMMENTS:

PLEASE NOTE:

The Student Health Service recommends the influenza vaccine. This vaccine is available at the Student Health Service at no additional charge to students.

SIGNATURE

DATE

Health Service Use Only:
Reviewed by: _____
Date: _____

