Office Use Only
VFC: [ ] V02 -- MDD
[ ] V03 -- No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP
INSURANCE:
Copay / Co-ins

Statement Balance

Asthma / Breathing Concerns

Office Use Only
WT: ______kg ______ lb
HT: _________________
Temp: _______________
Resp: _______________
Pulse: _______________
Oxygen: _____________
BP: _________________

Is this a follow-up appointment? Yes / No.

Child's name: ____**Child's birthday:** ______________________________

Who is your child's primary care physician? ____

Since your child's last visit:

- Does your child wheeze/cough (circle one)? Less than 2x/wk; More than 2x/wk; Everyday
- Number of nights your child woke up with asthma symptoms? ________
- Number of days your child's asthma got in the way of physical/social activities? _________
- Number of days your child missed school because of asthma? ________
- Does your child use a rescue/reliever inhaler more than twice a week? _________
- Has your child been to the EMERGENCY ROOM? ___________
- Has your child been HOSPITALIZED? ___________

Does your child:

- Use a Peak Flow Meter Yes / No
- Have an Asthma Action Plan Yes / No
- Use a mask or spacer with an inhaler Yes / No
- Have an inhaler at school Yes / No
- Use a nebulizer machine Yes / No

For Girls Only if Applicable
Last menstrual period was: _________________

Periods started at age:______________________

Any problems?___________________________
____

Other symptoms:

Fever	Yes / No. If yes, how long? _________	Abdominal pain	Yes / No. If yes, how long? _________
Nasal discharge	Yes / No. If yes, how long? _________	Decreased appetite	Yes / No. If yes, how long? _________
Earache	Yes / No. If yes, how long? _________	Nausea/Vomiting	Yes / No. If yes, how long? _________
Sore throat	Yes / No. If yes, how long? _________	Diarrhea	Yes / No. If yes, how long? _________
Headache	Yes / No. If yes, how long? _________	Rash	Yes / No. If yes, how long? _________

Does your child have a medication allergy? Yes / No. What medication/reaction? ____
Does your child have any chronic medical problems? Yes / No. If yes, please explain. _________________________________
Has your child been admitted to the hospital overnight? Yes / No. If yes, please explain. ___________________________
Has your child had any surgeries? Yes / No. If yes, please explain. ____
Is your child taking any daily prescribed medications? Yes/no. If yes, please explain. ______________________________
Is your child taking any over-the-counter cold medications? Yes/No. If yes, please list: ______________ Motrin or Tylenol? Yes/No
Has your child been around anyone who is sick? Yes / No. Who? ____
Does anyone in the family have:

Asthma	Yes / No	please circle: father / mother / brother / sister
Seasonal allergies	Yes / No	please circle: father / mother / brother / sister

Does anyone in the family smoke (includes outside of the house)? Yes / No. If yes, who? ___________________________
Any pets? Yes / No. Which kind/how many? ____
Does your child attend daycare/preschool/school? (please circle) What grade in school or daycare? _________________
Does your child participate in any sports? Yes / No. If yes, which sport(s)? ____________________________________
Are your child's immunizations up-to-date? Yes/no. If no, please explain. ______________________________________

This form completed by: ______________________________ **Relationship to Child:** ____________________ **Today's Date**_______________

Updated: 10/12/16