Producer _____ Phone _____ Fax _____

Client _____ Age/DOB _____ Sex _____

If your client has a history of Asthma, please answer the following:

1. Please list date of first diagnosis.

_____

2. Has your client ever been hospitalized for this condition?

☐ Yes. Please give details. _____

☐ No

3. How many episodes of asthma has your client had in the past year that required him/her to go to the ER or see their physcian for treatment?

_____

4. Has your client ever smoked?

☐ Yes, and currently smokes _____ (amount/day)

☐ Yes, smoked in the past but quit _____ (date)

☐ No, never smoked

5. Is your client on any other medications (include inhalers) or any medications taken on an "as needed" basis?

☐ Yes. Please give details. _____

☐ No

6. Have pulmonary function tests (a breathing test) ever been done?

☐ Yes. Please give details. _____

☐ No

7. Does your client have any abnormalities on an ECG or x-ray?

☐ Yes. Please give details. _____

☐ No

8. Does your client have any other major health problems (e.g., stroke, etc.)?

☐ Yes. Please give details. _____

☐ No