UNIVERSITY OF NEVADA SPORTS MEDICINE

Asthma History Checklist

Please circle everything that applies to you, and fill in blanks to the best of your knowledge.

1. **Current symptoms:**
   Cough Wheezing Sputum/mucus production Shortness of breath Chest tightness

2. **Symptom Pattern:**
   Present year round Seasonal Continuous Episodic Day time Night time Present with exercise

3. **Triggers:**
   Respiratory infections/colds Allergens (pollen, dust, animals) Cold air Exercise

   Irritants (cigarette smoke, perfume, strong smells) Medications Foods Change in weather

4. **Present Management:**
   Current medications: _____

   Response to medications: None Fair Good Great

5. **Disease Development:**
   Age of onset: _____

   Age of diagnosis: _____

   History of exacerbations:

   Hospital visits: (date) _____
   Urgent care or ER visits: _____
   Recent Antibiotic use (last 6 months):_____
   Recent steroid use (oral or IV, not inhaled, last 6 months):_____

6. **Disease Impact:**
   How much time away from school/work/sport in the past 3 month time frame? _____

   Do your symptoms limit activities/ability to practice/compete fully? _____

   Associated disorders (circle)? Allergic rhinitis, Sinusitis, Nasal polyps, Post nasal drip, Eczema

7. **Other comments/information:** _____