Asthma Pre-visit Worksheet (adult) **Name:** **Date:**

This worksheet will help you get ready for your first visit to talk to a doctor about your asthma.

How old were you when you were diagnosed with asthma? Age: _____ years No diagnosis: ☐

Do you have family members who have/had asthma? ☐ Yes ☐ No Relationship:_____

Anyone that has died from asthma? ☐ Yes ☐ No Relationship:_____

Have you ever (circle and add details):

Missed school or work for breathing issues? ☐ Yes ☐ No # Days _____ per month/ year

Woken up at night coughing? ☐ Yes ☐ No ☐ Every night OR # nights per month _____

Had coughing, noisy breathing or shortness of breath during the day? ☐ Yes ☐ No ☐ Every day OR # days per week_____

If you hear noisy breathing, does it happen when you breathe in? Or out? ☐ In ☐ Out

Had to limit your activities? ☐ Yes ☐ No

Gone to the Emergency Room for breathing issues? ☐ Yes ☐ No # in past year_____ # lifetime_____

Been hospitalized for asthma? ☐ Yes ☐ No # _____past year/ lifetime_____

Hospitalized in the ICU because of asthma? ☐ Yes ☐ No #_____ times in lifetime

Had to be Intubated (tube down throat to help breathe)? ☐ Yes ☐ No # _____times in lifetime

Taken oral steroids pills (prednisone) or shots in the past year? ☐ Yes ☐ No #_____

Possible triggers- things that make your breathing worse:

Have you ever smoked or vaped? ☐ Yes ☐ No # /day_____for # years_____

What have you smoked or vaped? ☐ Tobacco ☐ Marijuana ☐ Flavors

Do you smoke or vape now? ☐ Yes ☐ No # /day_____for # years_____

What do you smoke or vape? ☐ Tobacco ☐ Marijuana ☐ Flavors

Anyone in the house smoke? ☐ Yes ☐ No

Exposed to smoke outside the home? ☐ Yes ☐ No

Have you noticed anything in your environment that makes your breathing worse? (circle or check all that apply)

☐ Smoke ☐ Pets ☐ Colds/respiratory infections ☐ Pollen ☐ Mold/mildew ☐ Cockroaches

☐ Emotions ☐ Stress ☐ Strong chemicals ☐ Dust ☐ Changes in weather ☐ NSAIDs

☐ Air Pollution ☐ Being active outside ☐ Breathing cold air

☐ Exercise (type)_____ ☐ Other: _____

Do you have a history of eczema, hay fever or other allergies including foods? ☐ Yes ☐ No

Which months are the worst for your breathing? (circle or check all that apply)

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

What you know about asthma:

Do you feel like your asthma has been well controlled? ☐ Yes ☐ No

Do you feel that you understand how the lungs work and how they are different in asthmatics? ☐ Yes ☐ No

Do you feel that you know what triggers to avoid so you are less likely to have an asthma attack? ☐ Yes ☐ No

Do you feel like you take your medications correctly? ☐ Yes ☐ No

Do you ever miss any of your medication doses? If yes, how many days a week? _____ ☐ Yes ☐ No

Do you feel like you know what to do in the event of an asthma attack? ☐ Yes ☐ No

Do you have a current asthma action plan? ☐ Yes ☐ No

What medication have you taken in the past for breathing issues?

Medication Name	Medication Dose	How often taken	Why was it stopped?

What medications are you taking currently for breathing issues?

Medication Name	Medication Dose	How often taken	Is this medicine a controller or reliever medicine? (circle or check)
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐
			Controller ☐ Reliever ☐

If you have been taking inhalers (puffers), do you use a chamber/spacer? ☐ Yes ☐ No

What are your goals for your breathing? Circle or check all that apply

☐ Decrease the number of school days/work missed
☐ Sleep through the night
☐ Able to play sports or exercise
☐ Decrease the number of emergency room visits
☐ Able to be active outside
☐ No hospitalizations
☐ Feel like my asthma is under control
☐ **Other:**_____
☐ **Other:** _____

Do you have anything else that you would like to talk to your doctor about?