

**Instructions:** Fill out all information below to the best of your ability. If unsure about anything, please ask your Flight Surgeon/Physician for clarification. Form must be complete for waiver consideration.

**Diagnosis (please circle yes or no as applicable)**

Have you ever been diagnosed with asthma by a physician:	YES	NO
Was a measured breathing test (spirometry or peak flow) ever performed:	YES	NO
Have you ever been diagnosed with ANY of the following:	YES	NO
-Reactive Airway Disease		
-Wheezy bronchitis		
-Airway hyperresponsiveness		

**Symptoms leading to diagnosis/treatment (please circle yes or no as applicable)**

Breathlessness: Yes    No	Recurrent (>1/yr) episodes of bronchitis : Yes    No
Chest tightness/constriction: Yes    No	Activity limitation: Yes    No
Wheeze: Yes    No	Missed school or work: Yes    No
Cough: Yes    No	Emergency Room visits: Yes    No
Nocturnal waking from symptoms such as shortness of breath and/or cough : Yes    No	Hospitalizations: Yes    No
Any <u>recent symptoms</u> (within last 5 years): Yes(describe)    No	

**Inhaler use**

Circle types of inhalers and/or medications used from the list below

(\*\*If unknown, write “unknown” in the blank just to the right, and discuss with FS\*\*): \_\_\_\_\_

- Albuterol (ventolin/proventil) or levalbuterol (xopenex)
- Salmeterol (Serevent) or formoterol (Foradil)
- Beclomethasone (beconase), budesonide (pulmicort), fluticasone(flovent) or triamcinolone (azmacort)
- Advair (fluticasone/salmeterol) or Symbicort (budesonide/formoterol)
- Montelukast (Singulair)

Answer the following questions regarding any inhaler use:

Age of first inhaler USE: \_\_\_\_\_

Frequency of inhaler use: \_\_\_\_\_

Circumstances of inhaler use: \_\_\_\_\_

Last time inhaler/asthma medication PRESCRIBED: \_\_\_\_\_

Age of last inhaler USE: \_\_\_\_\_

**Steroid use (please explain in the blank to the right, as applicable)**

Been given any steroids (prednisone, solu-medrol, decadron) for respiratory complaints?: \_\_\_\_\_

**Pertinent Medical Hx (please explain any of these applicable histories in the blank to the right)**

History of aspirin allergy: \_\_\_\_\_

Personal history of Atopy (atopic dermatitis/eczema, allergic rhinitis or conjunctivitis): \_\_\_\_\_

Family history of Atopy (atopic dermatitis/eczema, allergic rhinitis or conjunctivitis): \_\_\_\_\_

Family history of Asthma, Cystic Fibrosis, or other lung disease: \_\_\_\_\_

Smoking history: \_\_\_\_\_

I certify that the above information is true to the best of my knowledge. (Pt sign) \_\_\_\_\_

I have reviewed the following document with the patient. (FS/AME sign) \_\_\_\_\_