ARMED FORCES BENEFIT ASSOCIATION 909 N. WASHINGTON STREET ALEXANDRIA, VA 22314

ASTHMA FORM

APPLICANT'S NAME: _____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY NUMBER:** _____-_____-_____

1. APPROXIMATE AGE AT ONSET: _____ **DATE OF LAST ATTACK:** _____/_____/_____

2. USUAL FREQUENCY OF ATTACKS (PER YEAR): _____

3. BRIEFLY DESCRIBE USUAL ATTACK: _____

_____

LIST DATES OF ANY EPISODES OF STATUS ASTHMATICUS: _____

4. LAST ASTHMA HOSPITALIZATION DATE: _____/_____/_____

NUMBER OF ASTHMA HOSPITALIZATIONS IN THE LAST 5 YEARS : _____

LAST VISIT TO AN EMERGENCY ROOM (OR SIMILAR EMERGENCY TREATMENT FACILITY): _____/_____/_____

NUMBER OF EMERGENCY ROOM VISITS (OR SIMILAR) IN THE PAST 2 YEARS (EXCLUDING HOSPITALIZATIONS): _____

_____

HAS TREATMENT EVER INCLUDED INTUBATION?: _____ **IF YES, HOW MANY TIMES?:** _____

5. DESCRIBE RESTRICTIONS OF YOUR ACTIVITIES BECAUSE OF ASTHMA (INCLUDING LOST WORK / SCHOOL TIME): _____

_____

6. DO YOU HAVE A CHRONIC COUGH?: _____ **IF SO, DESCRIBE (i.e. FREQUENCY, CIRCUMSTANCES, PRODUCTION, etc.):** _____

_____

7. DO YOU OR HAVE YOU EVER SMOKED?: _____ **IF STOPPED, LAST TIME SMOKED?:** _____

8. ARE YOU SHORT OF BREATH WHEN YOU ARE NOT HAVING AN ASTHMA EPISODE?: _____

9. DO YOU OR HAVE YOU EVER TAKEN ALLERGY SHOTS FOR DESENSITIZATION?: _____

10. HAVE PULMONARY FUNCTION TESTS BEEN PERFORMED?: _____ **IF "YES", PLEASE ATTACH LATEST REPORT.**

MEDICATION

LIST ALL MEDICATIONS YOU ARE CURRENTLY USING AND INDICATE DOSE AND FREQUENCY. CHECK ONE FOR EACH MEDICATION.

MEDICATION	DOSE	SEVERAL TIMES A DAY	AT LEAST ONCE DAILY	AT LEAST ONCE WEEKLY	AT LEAST ONCE MONTHLY