



REACTIVE AIRWAY DISEASE/ASTHMA EVALUATION FORM

Office of Medical Services

Privacy Act Notice This information is requested pursuant to the Foreign Service Act of 1980, as amended (22 U.S.C. 3084, 3901, and 3984). The primary purpose for soliciting this information is to make appropriate assignments abroad. Unless otherwise protected by medical privacy regulations, the information solicited on this form may be made available to appropriate agencies, whether state, local or foreign, for law enforcement and administration purposes. It may be disclosed pursuant to court order. Failure to provide this information may result in denial of a medical clearance and affect your Foreign Service eligibility.

* Must be completed for pre-employment applicants and eligible family members (EFM) with a history of Reactive Airway Disease (RAD)/Asthma. Content (of form) must be reviewed and documented for all employees and EFMs with history of RAD/Asthma.

Name of Examinee (*Last, First, MI.*) _____

Name of Employee _____

Dear Doctor, Based on the history provided to our medical staff, we believe this individual may have asthma or other reactive airway disease. We appreciate your assistance in providing the following information on her/him. Check all of the following symptoms that apply.

I. SYMPTOMS

- Wheezing Cough Shortness of Breath
 Chest Tightness Increased Sputum Exertional Fatigue
 Other: _____

Frequency of Symptoms _____

List the dates, the above mentioned symptoms were experienced, moving left to right beginning with the most recent.

First Date <i>(mm-dd-yyyy)</i>	Second Date <i>(mm-dd-yyyy)</i>	Third Date <i>(mm-dd-yyyy)</i>	Fourth Date <i>(mm-dd-yyyy)</i>	Fifth Date <i>(mm-dd-yyyy)</i>

To what degree do these symptoms interfere with activity level or work?

- None Seldom Frequently

Explanation of Above _____

II. INDICATORS OF CONTROL

Has this individual experienced any of the following within the past 5 years? Please include frequency.

- Nocturnal Awakenings Yes No Explain _____
 Increased Need of Short-Acting Beta₂-Agonists Yes No Explain _____
 Urgent Care/ER Visits Yes No Explain _____
 Life-threatening Exacerbations
 (*Attach discharge summary*) Yes No Explain _____

Smoking History _____

III. PROVOCATIVE FACTORS (*Triggers*)

- | | | | |
|---|---|----------------------------------|---------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> House Dust-Mites | <input type="checkbox"/> Foods | Specify _____ |
| <input type="checkbox"/> Animal Dander | <input type="checkbox"/> Mold | <input type="checkbox"/> Weather | Specify _____ |
| <input type="checkbox"/> Menses | <input type="checkbox"/> Viral Infection | <input type="checkbox"/> Pollen | Specify _____ |
| <input type="checkbox"/> Emotional Stress | <input type="checkbox"/> Smoke
(<i>Tobacco/wood</i>) | <input type="checkbox"/> Other | _____ |

IV. CLASSIFICATION (*Please check one of the following categories*)

- Bronchospasm (*Not exercise-induced*)
- Exercise-Induced Bronchospasm (*"Asthma"*)
- Asthma (*Mild intermittent - severe persistent*)

For moderate persistent and severe persistent categories, attach a copy of spirometry (PFT's or PEF's) results done within the last 6 months. (*This is required*)

Classification of Asthma Severity Choose the best description from the category below.

- Mild Intermittent - (Days/nights w/ S x s less than 2 months, fever greater than 80%, PEF variability less than 20%)
- Mild Persistent - (Days/nights with 3 to 4 months, fever greater than 80%, PEF variability 20 to 30%)
- Moderate Persistent - (Day/nights with greater than 5 months, fever greater than 60% less than 80%, PEF variability greater than 30%)
- Severe Persistent - (Continual days, frequent nights, fever less than 60%, PEF variability greater than 30%)

National Asthma Education Program, Expert panel Report, "Guidelines for the Diagnosis and Management of Asthma", N 1 H publication # 98-4051. 7/97

V. TREATMENT within the past 5 years *Please complete the table below.*

Name of Medication	Dose	Date(s) Started (mm-dd-yyyy)	Date(s) Finished (mm-dd-yyyy)
Over the Counter Inhalers, e.g., Primatene Mist			
Short Acting Beta ₂ Agonists-Inhalers, e.g., Proventil, Ventolin, Maxair			
Long Acting Beta ₂ Agonists-Inhalers, e.g., Serevent			
Corticosteroids-Inhalers, e.g., Azmacort, Flovent, Vanceril			
Corticosteroids-Oral/Injectable, e.g., Cortisone, Prednisone			
Nebulized inhalers, e.g., Provental, Atrovent, Intal			
Non-Steroidal Anti-Inflammatory Agents-Inhalers, e.g., Tilade, Intal			
Methylxanthines-Oral, e.g., Theophylline			
Leukotriene Modifiers, e.g., Accolate, Singulair			
Immunotherapy (allergy shots)			
Other			

In the past did this individual have a more severe form of asthma? Yes No

When? _____

Please describe what you believe would be optimal asthma management for this individual (*If different from above regimen*).

VI. PATIENT MANAGEMENT

Does this individual have a good understanding of his/her respiratory condition? Yes No

Explanation _____

Can this individual self-manage daily medications and exacerbations? Yes No

Explanation _____

Does this individual own and know how to use a Peak Flow Meter? Yes No

Explanation _____

Would this individual tolerate moderate to heavy air pollution? Yes No

Explanation _____

Would this individual tolerate elevation above 7,000 feet? Yes No

Explanation _____

Name of Physician

Address

Phone Number

Signature of Physician

Date (*mm-dd-yyyy*)