AIRMEN ASTHMA STATUS REPORT

Airman's Name:_____DOB:_____

1) Control: Stable (Good-No changes recommended) _____ Adequate__ _____ Poor _____

2) Treatment (List All Medications and dosages):_____

_____

_____

3) In the past year, has the patient:

- Had frequency of symptoms more than 2 days per week? Yes_____ No_____
- Used a short-acting beta agonist (rescue inhaler) Yes_____ No_____ How many times per week?_____
- Had any in-patient hospitalizations due to asthma? Yes_____ No_____If so, how many hospitalizations?_____
- Had any out-patient (clinic/urgent care) visits for exacerbations due to asthma? Yes_____ No_____How many?_____
- Required the use of oral corticosteroids? Yes_____ No_____ If so, how many times?_____

Need one (1) PFT reading during the last 90 days prior to FAA Exam:

*Attach copy of test results Date of test: _____

(PFT is NOT required if the only treatment is PRN use on one or two days a week of a short acting beta agonist. (e.g. albuterol)

Complications: _____

_____

Recommendations: _____

_____

Physician's Name: _____

(Please print)

Address:_____

City/State/Zip Code:_____

Physician's Signature: _____

Date: _____