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Asthmatic Patient

Patient's Name: _____ DOB: _____

Physician's Name: _____ Phone #: _____

What causes the attack: _____

When was the last attack: _____

Names of medications & dosages: _____

When are they taken: _____

Rate Asthma: Mild Moderate Severe (Circle One)

Has your child been hospitalized: YES NO (Circle One)

When: _____

Where: _____

Why: _____

I have been instructed that I must bring all asthma medicine, (inhaler, nebulizer, etc.), to all treatment appointments. It does not matter how long ago the asthma medicine was last used or what normally causes the attacks. I understand if the medicine is not brought to the appointment, treatment will not be performed on my child.

Parent's Signature

Date