

ASTHMA (History of Childhood Asthma or Inhaler use Worksheet)

Submit this completed form to IFCI/MFS (you may use N/A in fields other than Disqualifying Conditions fields).

MEMBER SECTION

DIAGNOSIS	YES	NO	INHALER USE	YES	NO
Have you ever been diagnosed with asthma?			Have you ever used an inhaler?		
Was a measured breathing test (spirometry or peak flow) ever performed?					
Have you ever been diagnosed with:			Age at first inhaler USE: _____		
• Reactive airway disease?			Frequency of inhaler use: _____		
• Wheezy bronchitis?			Circumstances of inhaler use: _____		
• Airway hyper responsiveness?			Date of last inhaler or other asthma medication prescription: _____		
SYMPTOMS LEADING TO DIAGNOSIS/TREATMENT					
Breathlessness?			Age at last inhaler use: _____		
Chest tightness/constriction?					
Wheeze?			Have you ever been prescribed steroid pills for respiratory complaints?		
Cough?			Do you have aspirin allergy?		
Waking at night with shortness of breath or cough?			Do you have atopic dermatitis, eczema, allergic rhinitis or conjunctivitis?		
Recurrent (>1/yr.) bronchitis?			Does anyone in your family have atopic dermatitis, eczema, allergic rhinitis or conjunctivitis?		
Activity limitations?			Does anyone in your family have asthma, cystic fibrosis, or other lung problems?		
Missed school or work?			Have you ever smoked?		
Emergency room visits?			Do you smoke now?		
Hospitalizations?			Did you grow up in a smoking household (parent or caregiver smoke in home)?		
Any symptoms in past 5 years?					

I CERTIFY that the above is TRUE to the best of my knowledge _____

MEMBER signature

Date

FLIGHT SURGEON SECTION

Baseline spirometry is normal (within 1yr of application, per pulmonary interpretation; upload report to AERO)	YES	NO	Aeromedical disposition:
MCCT is negative (within 1yr of application, per pulmonary interpretation; upload report to AERO)			
Health record reviewed and aeromedical status checked. Member is in compliance with all previous waivers and/or physical exam submission requirements.			With your signature, you are certifying that all above is true. Errors/omissions may be brought to attention of your clinical supervisor and/or privileging authority.
Diagnosis: Z87.09 Personal history of other diseases of respiratory system			FLIGHT SURGEON signature/stamp _____ Date _____

Date _____

Name _____

Soc. Sec. # _____