OMB Control No. 0420-xxxx
Expiration Date xx/xx/xxxx

Peace Corps

ASTHMA EVALUATION FORM

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported having Asthma. This form must be completed by the Health Care Provider (MD or DO as required by State laws) who provides, or provided, medical oversight and management of this health condition.

Note to the Provider: Please be candid when answering the questions below. During Peace Corps service, a Volunteer may be placed in a site that requires flexibility and physical endurance to adapt to unpredictable housing conditions, climate extremes, and unreliable transportation and to exhibit a heightened awareness for personal safety and increased attention to safe food and drinking water. Walking long distances on rough terrain is not uncommon. There may also be limited access to Western-trained health professionals and medical care. The most accurate representation of this condition is critical for the Peace Corps to make appropriate decisions for placement of the Volunteer. **Please answer all questions or the form will be considered incomplete and returned to the applicant.**

I. SYMPTOMS:

☐ Wheezing	☐ Cough	☐ Shortness of breath
☐ Chest tightness	☐ Increased sputum	☐ Exertional fatigue

☐ Other: _____

Date the patient first experienced symptoms:
_____

Date of *most recent* symptoms:_____

Burden Statement:
Public reporting burden for this collection of information is estimated to average 30 minutes per applicant and 75 minutes per mental health professional per response. This estimate includes the time for reviewing instructions and completing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: FOIA Officer, Peace Corps, 1111 20th Street, NW, Washington, DC 20526 ATTN: PRA (0420 - ####). Do not return the completed form to this address.
PC-262-2 (rev. 2/22/12)

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

☐ None ☐ Seldom ☐ Frequently

Explanation of above: _____

_____

II. INDICATORS OF CONTROL:

Has this applicant experienced any of the following *within the past five years*?

☐ Yes	☐ No	Nocturnal awakenings	Explanation	
☐ Yes	☐ No	Increased need of short-acting beta$_2$-agonists	Explanation	
☐ Yes	☐ No	Urgent care/ER visits	Explanation	
☐ No	☐ No	Life-threatening exacerbations ***(attach discharge summary)***	Explanation	

Smoking history: _____

-

III. PROVOCATIVE FACTORS (triggers):

☐ Exercise	☐ House dust-mites	☐ Foods	OTHER:	_____
☐ Animal dander	☐ Mold	☐ Weather	Specify:	_____
☐ Menses	☐ Viral infection	☐ Pollen	Specify:	_____
☐ Emotional stress	☐ Smoke (tobacco/wood)	☐ Other	Specify:	_____

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

☐ Bronchospasm ☐ Exercise-Induced Asthma ☐ Asthma

If this applicant is classified as having Asthma, please indicate the level of severity:

Classification of Asthma Severity*

Check Which Level of Severity Applies	Level of Severity	Days w/Sxs	Nights w/Sxs	FEV1	PEF variability
☐	Mild Intermittent	<2/wk	<2/mo	>80%	<20%

☐	Mild Persistent	3-6/wk	3-4/mo	>80%	20-30%
☐	Moderate Persistent	daily	>5/mo	>60%-<80%	>30%
☐	Severe Persistent	continual	frequent	<60%	>30%

*National Asthma Education Program, Expert Panel Report "Guidelines for the Diagnosis and Management of Asthma," NIH publication No. 98-4051. 7/97

I. TREATMENT within the past five years *(please complete table below):*

Name of Medication	Dose	Date(s) Started	Date(s)Finished	# of doses per/mo
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 ➢				

- Has the applicant ever experienced a more severe form of Asthma? ☐ Yes ☐ No
  If yes, when?

- Please describe the optimal asthma management plan for this patient (if different from above regimen):_

VI. PATIENT MANAGEMENT:

- Does the applicant have a good understanding of his/her respiratory condition?
  ☐ Yes ☐ No Explanation:

- Can the applicant self-manage daily medications and exacerbations?
  ☐ Yes ☐ No Explanation:
  -

- Does this applicant own and know how to use a Peak Flow Meter?
  ☐ Yes ☐ No Explanation:
  -

- Does the applicant have any functional limitations or restrictions due to this condition?

☐ Yes ☐ No

If "Yes" is marked, describe limitations or restrictions:

_____

_____

_____

What specific recommendations for medical care do you have regarding the management for this condition over the next three years? **All recommendations will help determine the Volunteer's country and site placement**_____

Do you have any concerns that would prevent this applicant from completing 27 months of Peace Corps service without disruption because of the applicant's respiratory condition? NOTE: Peace Corps Volunteers may serve in isolated areas or areas with limited access to Western-trained health care providers and systems. Please check one box below.

☐ I have no concerns. This applicant, with regard to Asthma, is healthy enough to complete 27 months of uninterrupted Peace Corps service provided the above recommendations for asthma can be accommodated.

☐ I am unsure that this applicant can complete 27 months of uninterrupted Peace Corps service due to Asthma. I recommend a period of stabilization for this condition and an updated assessment at a future date. Describe and include the length of time for stabilization:

_____

☐ I do not believe this applicant can complete 27 months of Peace Corps service without undue disruption due to Asthma.

I certify this information is, in my opinion, an accurate representation of the baseline status of Asthma for the applicant listed above.

Physician Signature/Title (MD or DO as required by state laws)

Physician Name (Print)

Date

Physician License Number/State

Physician Address