ALLERGY/ASTHMA QUESTIONNAIRE

Name: ____________________________________

Birthdate: ________________________________

Date: ____________________

Who is completing this form? ____

COUGH OR WHEEZE SYMPTOMS

HOW OFTEN HAVE THESE SYMPTOMS OCCURRED? (Cough, wheeze, shortness of breath, chest tightness or pain)

Please check one in each column

DAYTIME SYMPTOMS	NIGHT SYMPTOMS	DURING OR AFTER EXERCISE	EXTRA ALBUTEROL USE
❑ less than twice weekly	❑ less than twice monthly	❑ exercise symptoms may occur	❑ occasional use
❑ more than twice weekly	❑ more than twice monthly	❑ less than once weekly	❑ periods of daily use
❑ daily	❑ nightly	❑ frequent exercise symptoms	❑ daily use
❑ continuous	❑ continuous	❑ significant limitation activity	❑ frequent daily need

Please rank how severe symptoms are from 1-10 (1 the least and 10 the most) ____________________.

TRIGGERS OF COUGH OR WHEEZE:

❑ colds/infection
❑ morning
❑ night
❑ exercise
❑ cold air
❑ outdoors
❑ paint fumes
❑ changes in humidity
❑ school/work environment
❑ allergies ______________
❑ stress
❑ second hand smoke
❑ tobacco use
❑ perfume/aerosol sprays
❑ mile run time __________
❑ pneumonia/"bronchitis"

MONTHS OF SYMPTOMS:

❑ year round symptoms

❑ January	❑ April	❑ July	❑ October
❑ February	❑ May	❑ August	❑ November
❑ March	❑ June	❑ September	❑ December

ALLERGY - LIKE SYMPTOMS

UPPER RESPIRATORY SYMPTOMS

❑ sneezing
❑ sniffing/drippy nose
❑ itchy eyes/nose
❑ dark circles under eyes
❑ sinus infection
❑ mouth breathing/snoring
❑ congestion
❑ headaches

OTHER

❑ eczema
❑ hives
❑ dry skin
❑ itchy skin
❑ ear infection
❑ nausea
❑ dry cough
❑ throat clearing

MONTHS OF ALLERGY SYMPTOMS

❑ year round symptoms

❑ January	❑ April	❑ July	❑ October
❑ February	❑ May	❑ August	❑ November
❑ March	❑ June	❑ September	❑ December

Please rank how severe symptoms are from 1-10 (1 the least and 10 the most) ____________________.

EXPOSURES:

age of home_______ 2nd home/cabin_________ age of school _________ age of work/volunteer site ________

❑ Smoke
❑ fireplace/woodstove
❑ animals ______________
❑ feather (pillows, stuffed animals)
❑ carpeting
❑ bedroom carpeting
❑ forced air heat
❑ mold in lower level
❑ humidifier/vaporizer
❑ bedroom in lower level
❑ rural
❑ city
❑ suburbs

ENVIRONMENTAL CONTROLS

❑ air conditioning
❑ dehumidifier
❑ HEPA filter
❑ wood floors
❑ mattress & pillow covers

TESTING/EVALUATION/EDUCATION:

1. Has the patient ever had a breathing/lung function test? .... Y N

If yes, when? ____

2. Has the patient ever had allergy testing? .... Y N
3. Has the patient had their flu vaccine this year?.................................. Y N
4. Has the patient ever had flu vaccine? .... Y N
5. Do you have an action plan at home? .... Y N
6. Do you have an action plan at school/daycare? .... Y N
7. Do you have any questions about your action plan? .... N Y
8. Have you received asthma information? .... Y N

9 Would you like more information? .... N Y

❑ classes ❑ reading material ❑ websites

Please list below any questions or concerns that you would like to talk about today.

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Parent/Guardian Signature: ________________________________ Provider Signature: ______________________________