GENERAL ALLERGY & ASTHMA QUESTIONNAIRE

NAME: _____ DOB: _____ DATE:_____

1. Are you bothered by any of the following symptoms, at any time of the year? (circle all that apply)

Cough	Runny nose	Ear ringing
Bloating	Sneezing	Dizziness
Diarrhea	Decreased smell	Ear pain
Itchy eyes	Wheezing/Short of breath	Decreased hearing
Swollen eyes	Difficulty falling asleep	Reduced productivity
Itchy nose	Waking up at night	Reduced concentration
Itchy throat	Lack of a good night sleep	Restless/irritable
Stuffy nose/congestion	Wake up tired	Depressed/sad
Post Nasal Drainage	Ear fullness/pressure	Embarrassed

Which of the above symptoms bothers you the MOST? _____

2. Do you have asthma? □No - move to question #3. □Yes - please fill out below:

- Please fill out the asthma control test (see front desk staff, or download online)
- At what age were you diagnosed? _____
- Have you ever had a lung function test (spirometry) □ No □ Yes (approx date:_____)
- Have you been to the hospital because of asthma? □ No
  □Yes, it the last year: □Emergency Room Only □Hospitalized Overnight □Intensive Care
  □Yes, in the past. # times_____ Date of most recent: _____
- Have been on prednisone for asthma? □ No
  □Yes: # times/ages:_____
  How many in the last year? _____
- What medications are you on for your asthma?
  □ Albuterol/rescue. Name of inhaler (circle): Ventolin ProAir Xopenex Other:_____
  □ Maintenance steroid inhaler. Name of inhaler:_____
  □ Singulair/Montelukast
  □ Other:
- How often are you *actually* using your medication?
  *Albuterol/rescue (how many times per week do you need this?) _____
  *Maintenance inhaler (how often are you taking this, do you miss doses (circle all that apply):

Once Daily	I never miss a dose
Twice Daily	I may miss a dose or 2 a week
As Needed	I frequently forget

  *Singulair: Daily at night Daily in the morning #days/week you actually take this:_____
  Any concerns about your asthma? □ No □ Yes (please elaborate):

Name:_____ **DOB:** _____ **Date:**_____

3. How severe are your allergy symptoms, in general? (scale of 1-5, with 5 very severe):_____

4. At what age did your allergy symptoms start? _____

5. Is there a time of day, or season of the year that makes your allergies worse?

_____

6. Is there anything that makes your allergy (or asthma) worse? (circle all that apply)

Dust	Being outside	Exercise
Eating spicy food	Pollen	Animal exposure:_____
Being inside	Raking leaves	Certain food:_____
Mowing grass	Strong fumes	Other:
Musty smelling places	Strong odors	

7. Is there a family history of allergy or asthma (eg. parents, siblings)?

□ No □ Allergy (who?):_____ □Asthma (who?)_____

8. Do you have any of the following conditions? (circle all that apply)

Recurrent bronchitis	Recurrent sinus infections	Reflux
Daytime sleepiness	Snoring	Penicillin allergy
Face pain	Sleep apnea	Aspirin allergy
Face pressure	Recurrent sore throat	NSAID (ibuprofen) allergy
Headache	Urticaria (hives)	Food Allergies
History of nasal polyps	Angioedema (swelling)	Latex allergy
		Venom (bee sting) allergy

9. Home environment:

Are there pets at home? □ No

□ Yes: Type_____ Allowed in bedroom? □ No □ Yes

Are you exposed to any other animals (eg. horse, cattle, mice):

□ No

□ Yes: Type_____

Do you have an air purifier in your home? □ No □ Yes

Do you have an air purifier in your bedroom? □ No □ Yes

How old is your home? _____yrs.

How long have you lived there? _____

Basement: □ No □ Yes

Any obvious mold or mildew? □ No □ Yes

In what location do you live: □ City □Suburb □ Rural □ Ranch