Allergy & Asthma Questionnaire

Name: _____ DOB: _____ Date of visit: _____

ALLERGY SYMPTOMS: Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale →	**NO PROBLEM**	**VERY MILD PROBLEM**	**MILD /SLIGHT**	**MODERATE**	**MODERATE/SEVERE**	**VERY SEVERE**
RESPIRATORY SYMPTOMS:						
Cough	0	1	2	3	4	5
Itchy, watery eyes	0	1	2	3	4	5
Itchy nose or need to rub nose	0	1	2	3	4	5
Itchy throat	0	1	2	3	4	5
Stuffy nose/nasal congestion	0	1	2	3	4	5
Post-nasal discharge	0	1	2	3	4	5
Runny nose	0	1	2	3	4	5
Inconvenience of having to carry tissues or blow nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Decreased smell	0	1	2	3	4	5
Wheezing or shortness of breath	0	1	2	3	4	5
EAR SYMPTOMS:						
Fullness/Pressure	0	1	2	3	4	5
Ringing	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Pain	0	1	2	3	4	5
Decreased hearing	0	1	2	3	4	5
Do these ear symptoms get worse when your allergies are worse? Yes No						
SLEEP SYMPTOMS:						
Difficulty falling asleep	0	1	2	3	4	5
Wake up at night/ Lack of a good night's sleep	0	1	2	3	4	5
Snoring	0	1	2	3	4	5
Daytime tiredness	0	1	2	3	4	5
Wake in the AM with headache	0	1	2	3	4	5
Do you have sleep apnea? Yes No If yes, circle if you wear: CPAP, Mandibular Advancement Device						
GENERAL SYMPTOMS:						
Facial pain/pressure	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Headache	0	1	2	3	4	5
Reduced Productivity or Concentration	0	1	2	3	4	5
EMOTIONAL CONSEQUENCES: Do your allergies make you feel:						
Frustrated/Restless/Irritable	0	1	2	3	4	5
Depressed/Sad	0	1	2	3	4	5
Embarrassed	0	1	2	3	4	5

Which of these symptoms above bothers you the most? _____

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1. **Asthma History (if you do not have asthma, check □ No, and move to the next page).**
   - **At what age was your asthma diagnosed?** _____
   - **Have you ever had a lung function test (spirometry)** □ No □ Yes (Date? _____)
   - **Have you been to the hospital or urgent care because of asthma?** □ *No*
     □Yes # times_____ Date of most recent: _____
   - **Have been on prednisone for asthma?** □ *No*
     □Yes: # times/ages: _____ How many in the last year? _____
   - **Which medications have you HELPED your asthma, either now or in the past?**

Ventolin	Atrovent	Pulmicort	Dulera
Pro Air	Asmanex	Qvar	Symbicort
Xopenex	Alvesco	Advair	Singulair
Albuterol	Flovent	Breo	Prednisone

   - Have any of these medications FAILED to help you? _____
   - How often are you *actually* using your current medications? _____
     _____
   - **Any concerns about your asthma?** □ *No* □ *Yes (please elaborate*): _____

Asthma control test: Write the number of each answer in the score box provided. A total score of 19 or less may mean your asthma is not well controlled.

In the past **4 weeks**, how much did your asthma keep you from getting as much done at work, school or home?

All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	Not at all (5)	**Score:**

In the past **4 weeks**, how often have you had shortness of breath?

More than once a day (1)	Once a day (2)	3-6 times per week (3)	1-2 times per day (4)	Not at all (5)	**Score:**

In the past **4 weeks**, how much did your asthma symptoms (wheezing, cough, shortness of breath, chest tightness) wake you up at night or earlier in than usual in the morning?

4 or more nights a week (1)	2-3 nights/week (2)	Once a week (3)	Once or twice a week (4)	Not at all (5)	**Score:**

In the past **4 weeks**, how often have you used your rescue inhaler for asthma symptoms (not pretreating for exercise)

3 or more times/day (1)	1 to 2 times per day (2)	2 or 3 times per week (3)	Once a week or less (4)	Not at all (5)	**Score:**

How would you rate your asthma control during the past **4 weeks**.

Not at all controlled (1)	Poorly controlled (2)	Somewhat controlled (3)	Well controlled (4)	Completely controlled (5)	**Score**:

TOTAL SCORE: _____

Allergy & Asthma Questionnaire

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2. Allergy history:

- **How severe are your allergy symptoms, in general?** (scale of 1-5, with 5 very severe): _____
- **How have your allergies been over time** (circle): Getting better Getting worse Unchanged
- **At what age did your allergy symptoms start?** _____
- **Is there a season, or time of day that makes your allergy (or asthma) worse?** (circle all that apply)

  Spring Summer Fall Winter Time of day:

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

Dust	Mowing grass	Pollen	Strong odors
Spicy food	Musty smelling places	Raking leaves	Exercise
Being inside	Being outside	Strong fumes	Animal exposure

3. Family History: Is there a family history of allergy or asthma (eg. parents, siblings)? □ *No*

□ Yes, Allergy (who?): _____ □ Yes, Asthma (who?): _____

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

Recurrent bronchitis	Urticaria (hives)	Penicillin Allergy	Food Allergy
Nasal polyps	Angioedema (swelling)	Aspirin Allergy	Latex Allergy
Sinus infections	Reflux	NSAID Allergy	Bee Sting Allergy

Animal Exposure (circle all that apply*):* Cat Dog Horse Cattle Chicken Guinea Pig Rabbit Cockroach

Are any of these animals allowed in your bedroom? □ No □ Yes Is there a HEPA filter in the home? □ No □ Yes

Are you exposed to mold or mildew? □ No □ Yes Do you travel frequently? □ No □ Yes

6. Prior testing & Treatment:

Have you had any of these tests performed in the past? (circle all that apply):

Allergy Testing Chest X ray CT sinus CT lung Esophageal Endoscopy

Have you ever been on immunotherapy? □ No □ Yes **Do you carry an Epi Pen**? □ *No* □ *Yes*

Circle which medications have you HELPED your allergies, either now or in the past:

Flonase	Nasonex	Allegra	Xyzal	Azelastine	Pataday
Nasacort	XHance	Claritin	Zyrtec	Patanase	Zaditor
Singulair					

Have any of these medications failed to help you? _____

Prior Surgery: Have you had any of the following? (circle all that apply):

Ear tubes	Septoplasty	Tonsillectomy
Mastoidectomy	Sinus surgery	Turbinate reduction