Millhon Clinic

OhioHealth

ASTHMA QUESTIONAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

How were you referred to our office? Physician (Name): _____ ☐ Self Referral Other: _____

What issue(s) have you been experiencing that bring you to this appointment?: _____

_____

_____

Do you have any of the following symptoms?:

☐ Cough	☐ Itchy eyes	☐ Blocked ears
☐ Wheezing	☐ Phlegm (color): _____	☐ Hives
☐ Sneezing	☐ Watery eyes	☐ Nasal Congestion
☐ Chest tightness	☐ Nasal polyps	☐ Swelling
☐ Shortness of breath	☐ Poor sense of smell	☐ Headaches
☐ Runny Nose	☐ Ear infections	☐ Snoring
☐ Post nasal drop	☐ Eczema	☐ Fatigue
☐ Itchy nose	☐ Rash	☐ Other _____

Check any of the following which may trigger (or cause) symptoms or bother you:

☐ Grass	☐ Alcohol	☐ Smoke
☐ Hay	☐ Cosmetics	☐ Pollution
☐ Wool	☐ Aerosol Spray	☐ Exercise
☐ Horses	☐ Perfumes	☐ Nervousness
☐ Old leaves	☐ Insecticide	☐ Cold air
☐ Cats	☐ Odors	☐ Humidity
☐ Dogs	☐ Basements	☐ Weather Changes
☐ Other animals	☐ Drafts	☐ Latex
☐ Beverages	☐ House dust	☐ Other: _____

When did symptoms begin? _____

Are your symptoms getting worse? ☐ Yes ☐ No

Do you experience symptoms daily? ☐ Yes ☐ No

When are your symptoms worse?

☐ Year Round ☐ January ☐ February ☐ March ☐ April ☐ May ☐ June

☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

When are your symptoms worse?

☐ At night ☐ In the morning ☐ Indoors ☐ Outdoors ☐ At home ☐ At work ☐ At School

Are symptoms better away from home? ☐ Yes ☐ No

Have you been skin tested? ☐ Yes ☐ No If yes, when: _____

Results: _____

Have you had allergy injections? ☐ Yes ☐ No If yes, when: _____

Have received cortisone, prednisone, methylprednisolone, etc? ☐ Yes ☐ No

When? _____ How much? _____

Occupation (if applicable): _____

Any harmful exposures at work or school? ☐ Yes ☐ No

How many days of school/work have you missed this year? _____

Have symptoms ever required you to be treated in the emergency room? ☐ Yes ☐ No

Have symptoms ever required staying overnight or extended stay in the hospital? ☐ Yes ☐ No

Environmental Survey:

How long have you lived in your house/apartment? _____

Do you live in a ☐ House ☐ Condominium ☐ Apartment/Duplex ☐ Mobile Home

Approximately how old is your home? _____

Do you live in ☐ the city ☐ the suberbs ☐ a rural area

Do you have a basement? ☐ Yes ☐ No

Is your dwelling built on a slab? ☐ Yes ☐ No

What type of heating system do you have? ☐ Hot Air ☐ Steam (radiator) ☐ Electric ☐ Gas ☐ Hot water (base board)

Do you have: ☐ Coal Stove ☐ Wood Stove ☐ Humidifier ☐ Dehumidifier

Pets: How many? _____ ☐ Indoor ☐ Outdoor ☐ Cats ☐ Dogs ☐ Birds ☐ Other _____

Are there smokers in your home? ☐ Yes ☐ No If yes what type? _____

Is your bedroom in the basement? ☐ Yes ☐ No

Do you have an air purifier/cleaner? ☐ Yes ☐ No

Do you have allergy-proof encasing for pillows? ☐ Yes ☐ No Mattress? ☐ Yes ☐ No

What type of pillow do you have? _____

What type of comforter do you have? _____ Blankets? _____

Why type of floor covering do you have? ☐ Carpeting ☐ Area Rug ☐ Animal skin rugs ☐ Wood ☐ Pergo ☐ Linoleum

How old is your mattress? _____ What is in your mattress? (i.e. cotton, down, horse hair etc.) _____

Do you have air conditioning? ☐ Yes ☐ No If yes, ☐ Window unit ☐ Central

Do you have stuffed animals in your bedroom? ☐ Yes ☐ No If yes, approximately how many? _____

Do you have problems with roaches? ☐ Yes ☐ No

Do you have problems with mice? ☐ Yes ☐ No

Do you have water leaks? ☐ Yes ☐ No Mold Contamination? ☐ Yes ☐ No

Is your home/apartment excessively humid? ☐ Yes ☐ No

Is your home/apartment excessively dry? ☐ Yes ☐ No

Medical History

Check all that apply:

☐ Diabetes	☐ Osteoporosis	☐ Hay fever
☐ Asthma	☐ Kidney disease	☐ Sinusitis
☐ Glaucoma	☐ Emphysema	☐ TB
☐ Hiatus Hernia	☐ Anxiety	☐ Depression
☐ High blood pressure	☐ Peptic ulcer	☐ Seizures
☐ Heartburn/Reflux	☐ Thyroid	☐ Pneumonia
☐ Liver disease	☐ Bonchitis	☐ Nasal Polyps
☐ Heart problems	☐ Eczema	☐ Other _____
☐ Cataracts	☐ Hives	_____

If yes to any of the above, please explain: _____

_____

Have you had your tonsils or adenoids removed? ☐ Yes ☐ No

Have you ever had ear or nose surgery? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Please indicate any blood relative who have/had the following conditions and their how they are related:

☐ Asthma _____	Other lung diseases or illnesses: _____
☐ Eczema _____	_____
☐ Hay fever _____	Other allergies and allergy symptoms: _____
☐ Swelling _____	_____
☐ Hives _____	

Please any hospitalizations regardless of cause: _____
_____
_____

Please list any food allergies and reactions experienced: _____
_____
_____

Please list any drug allergies and reactions experienced (i.e., penicillin, aspirin, sulfa, latex, codiene, etc.): _____
_____

Describe any reaction to insect stings: _____
_____

Current Medications: List all medication and dosages your are taking: (including nasal sprays, non-allergy medications, over-the-counter and alternative/herbal products)

	Medication	Dose Amount	How often taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you smoke now? ☐ Yes ☐ No How often/How much? _____
Have you smoked in the past? ☐ Yes ☐ No When did you quit? _____
Do you have a peak flow meter? ☐ Yes ☐ No

Questionaire reviewed by (physician): _____ Date: _____
(Print Name) (Signature)