ALLERGY/ASTHMA QUESTIONNAIRE

Name: _____

Birthdate: _____

Children's MINNESOTA
Partners in Pediatrics

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
- ❑ less than twice weekly
- ❑ more than twice weekly
- ❑ daily
- ❑ continuous

NIGHT SYMPTOMS
- ❑ less than twice monthly
- ❑ more than twice monthly
- ❑ nightly
- ❑ continuous

DURING OR AFTER EXERCISE
- ❑ exercise symptoms may occur
- ❑ less than once weekly
- ❑ frequent exercise symptoms
- ❑ significant limitation activity

EXTRA ALBUTEROL USE
- ❑ occasional use
- ❑ periods of daily use
- ❑ daily use
- ❑ 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
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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.

_____

_____

_____

Parent/Guardian Signature: _____ Provider Signature: _____