

## ALLERGIES/ASTHMA QUESTIONNAIRE

Name of person completing questionnaire:		Date:
Applicant's Name:		Date of Birth:
Social Security Number:	Height:	Weight:
Last Doctor's visit:	Any surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractor: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s):		Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Any auto/work related injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical conditions or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- When first diagnosed? \_\_\_\_\_
- Type of treatment? \_\_\_\_\_  
     Current treatment and medications: \_\_\_\_\_  
     How often is treatment? \_\_\_\_\_
- Any steroid use?  Yes  No  
     Currently taking steroids?  Yes  No  
     How often? \_\_\_\_\_  
     When did steroid treatment start? \_\_\_\_\_  
     If steroid use stopped, when? \_\_\_\_\_
- Smoker?  Yes  No
- How often in a 12-month period do you consult a doctor for this condition? \_\_\_\_\_
- Last time seen by a Doctor for this condition: \_\_\_\_\_  
     Doctor's name and address: \_\_\_\_\_

### ALLERGIES:

- Any asthma?  Yes  No
- Seasonal or year-round? \_\_\_\_\_
- Do you, or have you required allergy shots?  Yes  No

### ASTHMA:

- Allergy related?  Yes  No
- Exercise induced?  Yes  No
- Current medications – names, milligrams (pill, shot or inhaler): \_\_\_\_\_  
     How often is medication taken? \_\_\_\_\_
- Hospitalizations?  Yes  No      Emergency Room?  Yes  No  
     When? \_\_\_\_\_  
      Inpatient  Outpatient  
     For how long? \_\_\_\_\_
- Any breathing machines (nebulizer, etc.)? \_\_\_\_\_  
     Frequency of use? \_\_\_\_\_
- Have you ever been diagnosed, or suspicion of emphysema, chronic bronchitis, bronchiectasis or COPD (Chronic Obstructive Pulmonary Disorder)?  Yes  No

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, all statements and answers on this questionnaire are complete and true. If any information should result as false or inaccurate, I understand my coverage will be terminated at any time.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date