

ASTHMA AND RESPIRATORY DISORDERS QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM / DD / YY		

2. DIAGNOSIS

Please provide details about when the condition was diagnosed:

Date of first visit	Details	
MM / DD / YY	Symptoms	
	Diagnosis	

Has the patient undergone pulmonary surgical intervention? Yes No If "Yes", please provide details.

Is the patient still undergoing treatment? Yes No If "Yes", please provide details, name of medication, and dosage.

How often do attacks occur, and how long do they last?

Frequency		Duration		Date of last attack	MM / DD / YY
How are the attacks considered?		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Last visit to emergency room			Last admission to a hospital		
Date	Yearly frequency of visits to emergency room	Date	Yearly frequency of hospital admissions		
MM / DD / YY		MM / DD / YY			

Please provide the following information:

Date	MM / DD / YY	Height	<input type="checkbox"/> M <input type="checkbox"/> Ft	Weight	<input type="checkbox"/> Kg <input type="checkbox"/> Lb
Date	Spirometry (RESPIRATORY FUNCTION TEST)				
MM / DD / YY					
Date	Chest X-rays interpretation (PLEASE INCLUDE RADIOLOGY REPORT)				
MM / DD / YY					
History of smoking		Other comments			
Amount per day					
Number of years					

Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere? Yes No
 If "Yes", please fill the information requested below:

Physician's name		Telephone	
Outpatient treatment			
Hospital		Telephone	
Hospital treatment			

3. TREATING PHYSICIAN'S INFORMATION

Name	Last		First		M.I.
Address					
Telephone		Fax		Email	
Date	MM / DD / YY	Signature			