

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?		☐ Mild ☐ Moderate ☐ 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	☐ M ☐ Ft		Weight	☐ Kg ☐ 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				