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 the 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			