Respiratory Symptom Survey

Patient Name: _____ DATE: _____ Date of Birth: _____

COMMON SYMPTOMS: Circle the number according to severity: 0=None, 1=Mild, 5=Very Severe

Abdominal Gas or Cramping	0	1	2	3	4	5		Hives	0	1	2	3	4	5
Arthritis or Muscle Pain	0	1	2	3	4	5		Hyperactivity	0	1	2	3	4	5
Asthma	0	1	2	3	4	5		Itching	0	1	2	3	4	5
Cough	0	1	2	3	4	5		Nasal Congestion	0	1	2	3	4	5
Eczema	0	1	2	3	4	5		Poor Memory or Concentration	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5		Sneezing	0	1	2	3	4	5
Frequent Colds or Sore Throats	0	1	2	3	4	5		Trouble Breathing While Sleeping	0	1	2	3	4	5
Frequent Sinus or Ear Infection	0	1	2	3	4	5		Wheezing	0	1	2	3	4	5
Headache	0	1	2	3	4	5		Watery, Red, Itchy Eyes	0	1	2	3	4	5
Dry Eyes	0	1	2	3	4	5		Burning Eyes	0	1	2	3	4	5

SYMPTOM SCORE: _____ List any other current symptoms:_____

HISTORY:

Are there any foods which cause you any problems? _____
Symptoms: _____
Do you have a history of allergies? ( ) Yes ( ) No If yes, how long have you had allergies? _____
What season(s) do your allergies usually flair up? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) All Year
Have you been allergy tested before? ( ) Yes ( ) No. If yes, when _____
Does any medication give you relief of your allergy symptoms? ( ) Yes ( ) No Comment _____
Do you have pets at home? ( ) Yes ( ) No Type:_____
Are you exposed to fumes or dust? ( ) Yes ( ) No Comment _____
Do you smoke? ( ) Yes ( ) No How much? _____
Are you exposed to smoke in your environment? ( ) Yes ( ) No
Who else in your family has allergies/asthma? ( ) Mother ( ) Father ( ) Sibling ( ) Children
Have you been diagnosed with asthma? ( ) Yes ( ) No If so when? _____ Severity: ( ) Mild
( ) Moderate ( ) High
Do you think your asthma is under control? ( ) Yes ( ) No
How often do you use your inhaler?_____Last date used?_____
Are you taking any sleep aids? (include OTC) _____

CONTRAINDICATIONS:

Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No
Ever had a severe allergic reaction? ( ) Yes ( ) No Hospitalization due to allergies? ( ) Yes ( ) No
Taking Beta Blockers to treat Heart Disease? ( ) Yes ( ) No Medication:_____
Have you taken any allergy, antihistamine, cold medicine or sleep aides in the past 72 hours? ( ) Yes ( ) No
Are you pregnant? ( ) Yes ( ) No ( ) N/A