

ASTHMA / ALLERGY QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Ever diagnosed with: Asthma _____ Allergies _____
2. Are your allergies / asthma seasonal? ___ Yes ___ No
How many episodes per year? _____ Date of last attack? _____
Have you ever been treated for any other respiratory disorder? If so, please advise: _____

3. Have you had an asthma attack requiring doctor's visit, hospitalization(s) or emergency room visits for this condition? ___ Yes ___ No If yes, provide details to the following:
- a. Reason for seeking treatment or confinement? _____
 - b. Date(s) of confinement/visits: _____
 - c. Number of visits/confinements: _____
 - d. Name and address of doctor/hospital where seen: _____

4. Any work loss or restricted activities? _____

5. Diagnostic studies done:
- | | | |
|---------------------|------------------------|-----------------------|
| ___ Allergy testing | ___ X-ray studies | ___ Specialist's exam |
| ___ Bronchoscopy | ___ Pulmonary function | |

6. **Details of treatment:**
Medications taken **"regularly"**:
- | Name of Medication: | Dosage in mg.: | # Daily |
|----------------------------|-----------------------|----------------|
| _____ | | |
| _____ | | |

Medication taken seasonal:	Dosage in mg.:	# Months/days Requiring Treatment:
Name of Medication:		

Desensitization shots? Yes ___ No ___ Frequency? _____
Use of Nebulizer? Yes ___ No ___ If Yes, frequency? _____
Have you ever had to take oral or IV steroids? If Yes, provide details: _____

7. How often do you see the doctor for this condition: _____
Name and address of treating physician _____

8. What is your current height? _____ Weight? _____

9. Have you ever used tobacco products? Yes ___ No ___ How long? _____
If you have stopped, when did you quit? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent / guardian if under 18)

Date