

Allergy/Asthma Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: _____ ID/SSN: _____

Form No. _____

Name of person treated: _____ Relationship to applicant: _____

1. Diagnosis: Allergies Asthma

2. Date diagnosed or date of first symptoms: _____

3. Date of last episode: _____

4. Number of episodes in the last year: _____ Do episodes occur with the change of seasons? Yes No

5. Have there been any hospitalizations or emergency room visits for this condition? Yes No

If yes, please give date(s) of admission and discharge: _____

6. Any loss of work or restricted activities? Yes No If yes, please explain: _____

7. Have you ever been diagnosed with any of the following? Yes No (Please circle)

Bronchitis **Chronic obstructive pulmonary disease (COPD)** **Emphysema** **Pneumonia**

If yes, please explain details such as when and how often: _____

8. Have you ever had any of the following tests done? Yes No (Please circle)

Allergy testing **Bronchoscope** **X-rays** **Pulmonary function** **Specialist exam**

Results/findings? _____

9. Have you been prescribed any medications for this condition? (such as inhalers, steroids, etc.) Yes No

If yes, please list:

Name of medication	Amount taken per day	How often per day
---------------------------	-----------------------------	--------------------------

10. Is medication taken on a daily basis or as needed basis? _____ How often per year? _____

11. Desensitization shots? Yes No If yes, how often: _____

12. Nebulizer treatments? Yes No If yes, how often: _____

13. How often do you see the doctor for this condition?: _____

14. Name, address and phone number of treating physician: _____

15. Have you ever used tobacco products? Yes No If yes, for how long? _____ How much per day? _____.
If you have stopped, when did you discontinue use? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

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

Date