

SOUTH LAKE PEDIATRICS
PARENT ASTHMA TRIGGER QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

*CHECK ANSWERS THAT APPLY

- Does your child develop asthma symptoms at:
- Home
 - Daycare
 - School
 - Work
- What time of year are asthma symptoms worse:
- Summer: Jun/Jul/Aug
 - Fall: Sep/Oct/Nov
 - Winter: Dec/Jan/Feb
 - Spring: Mar/Apr/May
- Does your child have congestion or post nasal drip:
- Yes - Constant or Seasonal
 - No
- Does your child have symptoms with:
- Colds/Flu
 - Stress
 - Weather Changes
 - Air Quality Alerts
 - Cold Air
 - Exercise
 - Air Freshener Products
 - Dust
 - Other: _____
- Does your child have symptoms after ingesting certain foods or medications:
- Yes – List: _____
 - No
- Is there any history of recurrent spitting up, vomiting or heartburn in the past:
- Yes
 - No
- Does anyone in your household/daycare smoke:
- Yes
 - No
- Do any of the following trigger asthma symptoms:
- Menses
 - Thyroid Disease
 - Toxic Fumes (glue, etc)
 - Other: _____
- How old is your home:
- < 5 Years
 - 5 – 10 Years
 - > 10 Years

Please Complete Both Sides

Does your house have or household members use:

- Perfume
- Air Freshener Products
- Fireplace
- Wood Burn Stove
- Remodeling
- Mold
- Dampness/Moisture
- Humidifier
- Cockroaches
- Pets: _____
(List)

Does your child's bedroom have:

- Blinds
- Curtains
- Bookshelves
- Down/Feather Pillows
- Stuffed Animals
- Carpeting

Does your child spend time in the basement of your home: Yes
 No

Is your home or child exposed to:

- Dust
- Gasses
- Strong Odors
- Pollutants
- Occupational Chemicals
- Perfume/Cologne

Have you used methods for dust or mite control:

- Yes
List: _____
- No

Date Clinician Signature
