

SOUTH LAKE PEDIATRICS
PATIENT ASTHMA TRIGGER QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

*CHECK ANSWERS THAT APPLY

Do you 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

Do you have congestion or post nasal drip:

- Yes - Constant or Seasonal
- No

Do you have symptoms with:

- Colds/Flu
- Stress
- Weather Changes
- Air Quality Alerts
- Cold Air
- Exercise
- Air Freshener Products
- Dust
- Other: _____

Do you 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 bedroom have:

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

Do you spend time in the basement of your home:

- Yes
- No

Is your home or are you 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

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____