SOUTH LAKE PEDIATRICS
PATIENT ASTHMA TRIGGER QUESTIONNAIRE

South Lake Pediatrics
Infant, Child & Adolescent Care

PATIENT NAME: _____ **DOB:** _____

CHECK ALL ANSWERS THAT APPLY

1. Are asthma symptoms present at:
   ☐Home ☐Daycare ☐School ☐Work

2. What time of year are asthma symptoms worse:
   ☐**Summer:** Jun/Jul/Aug ☐**Fall:** Sep/Oct/Nov ☐**Winter:** Dec/Jan/Feb ☐**Spring:** Mar/Apr/May

3. Does the patient have congestion or post nasal drip:
   ☐Yes - Constant or Seasonal ☐ No

4. Does the patient have symptoms with:
   ☐Colds/Flu ☐Stress ☐Weather Changes ☐Air Quality Alerts ☐Cold Air ☐Exercise
   ☐Air Freshener Products ☐Dust ☐Other: _____

5. Does the patient have symptoms after ingesting certain foods or medications:
   ☐Yes – List: _____ ☐No

6. Is there any history of recurrent spitting up, vomiting or heartburn in the past:
   ☐Yes ☐No

7. Does anyone in your household/daycare smoke:
   ☐Yes ☐No

8. Do any of the following trigger asthma symptoms:
   ☐Menses ☐Thyroid Disease ☐Toxic Fumes (glue, etc) ☐Other: _____

9. How old is your home:
   ☐< 5 Years ☐ 5 – 10 Years ☐ > 10 Years

10. Does your house have or household members use:
    ☐Perfume ☐Air Freshener Products ☐Fireplace ☐Wood Burn Stove ☐Remodeling
    ☐Mold ☐Dampness/Moisture ☐Humidifier ☐Cockroaches ☐Pets: _____
    (List)

11. Does the patient's bedroom have:
    ☐Blinds ☐Curtains ☐Bookshelves ☐Down/Feather Pillows ☐Stuffed Animals
    ☐Carpeting

12. Does the patient spend time in the basement of your home:
    ☐Yes ☐ No

13. Is your home exposed to:
    ☐Dust ☐Gasses ☐Strong Odors ☐ Pollutants ☐Occupational Chemicals ☐Perfume/Cologne

14. Have you used methods for dust or mite control:
    ☐Yes List: _____ ☐No

_____ _____
Clinician's Signature Date