

**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"**:
- | <b>Name of Medication:</b> | <b>Dosage in mg.:</b> | <b># Daily</b> |
|----------------------------|-----------------------|----------------|
| _____                      |                       |                |
| _____                      |                       |                |

- | <b>Medication taken seasonal:</b> | <b>Dosage in mg.:</b> | <b># Months/days Requiring Treatment:</b> |
|-----------------------------------|-----------------------|---|
| <b>Name of Medication:</b>        |                       |   |
| _____                             |                       |   |
| _____                             |                       |   |

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