MVP SERVICE SOLUTIONS

ASTHMA / ALLERGY QUESTIONNAIRE
(complete all questions)

Producer Name: ________________________ Phone: ________________

Client Name: ________________________ State: __________ Date: __________

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"***:
   Name of Medication: **Dosage in mg.**: **# Daily**

   ____

   ____

   Medication taken seasonal:
   Name of Medication: **Dosage in mg.:** **# Months/days Requiring Treatment:**

   ____

   ____

   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? ________________

10. Please provide any additional medical issues or medical information:

Please fax completed form to 612-392-7644 or email to mvp@mvpservicesolutions.com