

# Asthma / Allergy Questionnaire

**Claims Administrator:**  
Consociate • Dansig  
Attn: Underwriting  
111 E. Decatur Street, P.O. Box 1068  
Decatur, IL 62525  
Phone: (888) 242-4357  
Fax: (217) 451-9088

Group name: \_\_\_\_\_

Employee name: \_\_\_\_\_

Dependent name (if condition is for dependent) \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. Diagnosis (circle one):      Asthma                      Allergies                      Both  
     For a diagnosis of asthma:      Mid                      Moderate                      Severe

2. Date of onset: \_\_\_\_\_

3. Date of last Doctor visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

4. Medication / Inhaler / Shots	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Treated with steroids or adrenaline?    Yes    or    No    If yes, please explain:

\_\_\_\_\_

5. Number of attacks per year? \_\_\_\_\_ Last one: \_\_\_\_\_

6. Any hospitalizations due to asthma / allergy?    Yes    or    No

Date	Treatment
_____	_____
_____	_____
_____	_____
_____	_____

7. Have you ever, or do you currently use any tobacco products, including cigarettes, cigars, chewing tobacco, etc?    Yes    or    No

If yes, length of time used: \_\_\_\_\_

If not currently using, how long ago did you quit? \_\_\_\_\_

Please be advised that you may be required to submit medical records.

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

