Aspirin Exacerbated Respiratory Disease (AERD)/Samter’s Triad Patient Questionnaire

Patient Name: Date Of Birth: Today’s Date:

Address:

Occupation:

Telephone: Home: Cell: Work:

Name of referring physician:

Address of referring physician:

What other health care providers have you seen? (Include provider’s name and specialty)

**ALL PATIENTS MUST BRING AN UP-TO-DATE AND ACCURATE LIST OF ALL MEDICATIONS THEY ARE CURRENTLY USING OR HAVE TAKEN IN THE PAST 6 MONTHS (including dosages)**

What are the main reasons for your visit today?:

__________________________________________________________

__________________________________________________________
Do you have any of the following? (Please circle your replies)

- sneezing
- blocked nose or congestion
- watery nose
- shortness of breath
- wheezing
- chest tightness
- cough
- sputum (phlegm)
- coughing at night
- severe itching
- severe swelling
- acid stomach / heartburn
- difficulty breathing
- rash
- chest pain
- frequent fevers

Have you been told, or do you suspect you have any of the following? (Please circle your replies)

- sinusitis
- ear infections
- nasal polyps
- chronic bronchitis
- eczema
- hives
- stomach reflux
- allergic rhinitis / hay fever
- pneumonia
- asthma
- frequent infections
- hypothyroid / abnormal thyroid

During which times of year are your symptoms the worst? (Please circle your replies)

- Spring
- Summer
- Fall
- Winter
- Always bad

What things make your symptoms worse? (Please circle your replies)

- respiratory infections / "colds"
- cold air
- Allergens:
- emotions – stress
- exercise
- animals/pets
- tobacco smoke / pollution
- weather changes
- dust
- strong odors
- alcoholic beverages
- pollens
- aspirin
- medicines like ibuprofen, naproxen ("NSAIDs")
- mold

Other triggers: ____________________________________________
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Does your illness lower your ability to exercise or to do any physical activity?

Do you have any other medical problems? Please describe:

What tests have been done for you?

<table>
<thead>
<tr>
<th>Test</th>
<th>Year of testing and Results</th>
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<tbody>
<tr>
<td>Allergy skin prick tests</td>
<td></td>
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<tr>
<td>Allergy blood tests (RAST)</td>
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<tr>
<td>Chest or sinus X-Ray</td>
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<td>Other tests</td>
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</table>

Do you have any other Allergies?

Medication allergies (other than aspirin/NSAIDs):

Food/Food additives:

Insects (Describe reactions):

Have you ever had immunotherapy? If so, how well did it work?

Have you ever had a severe allergic reaction (anaphylaxis)?

Asthma History

Have you ever been diagnosed with asthma? Yes No Age at diagnosis:

Number of visits for asthma (lifetime) to emergency room:

Number of hospitalizations for asthma (lifetime):

History of “Life-threatening” attacks? Yes No Intubated: Yes No

Number of days you have been on oral steroids (prednisone) in past year (approximate):

Nasal Polyp History

Have you ever been diagnosed with nasal polyps? Yes No Age at diagnosis:

If so, how many lifetime polyp surgeries have you had?

If so, how long does it usually take your polyps to grow back after surgery?
Rash History

Do you ever get episodes of an itchy rash or hives?  Yes  No

If so, which medications have you tried to treat the rash or hives?

Aspirin / NSAID Reaction History

Have you ever had reactions to any of the following medications?  (Please circle your replies)

- Aspirin
  (Excedrin, Alka-Seltzer)
- Ibuprofen
  (Motrin, Advil)
- Naproxen
  (Aleve, Anaprox)
- Ketorolac
  (Toradol)
- Acetaminophen
  (Tylenol)

How old were you when you first had a reaction to any of the above medications?  ________________

What happened to you when you had a reaction to these medications?  (Circle all that apply):

- Nasal congestion or runny nose
- Eye watering or redness
- Cough, wheezing, tightness in the chest
- Nausea or stomach pain
- Headache or face pain
- Hives or rash
- Flushing of the skin
- Other: ________________

Did you use any of the following treatments for your reactions?  (Circle all that apply):

- Antihistamines
  (Benadryl, Allegra, Zyrtec, Claritin)
- Albuterol or other rescue inhaler
- Steroids taken by mouth
- Steroids taken through a vein
- Epinephrine (EpiPen)

How long was it from the time you took the medication to the start of reaction symptoms?

- less than 30 minutes
- 30 minutes to 3 hours
- more than 3 hours

Tobacco Smoking & Alcohol History

Have you ever smoked tobacco?  Yes  No  Date stopped: ____________________

Number of years smoked: ____________________  Approximate packs per day: ____________________

Have you ever lived with someone who smoked?  Yes  No  If yes, for how long? ____________________

In which type of environment did you grow up?  Rural  Suburban  City

Have you ever used recreational drugs (marijuana, cocaine, ecstasy, etc)?  Yes  No
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Do you drink alcohol: Yes  No

Do you ever have any of the following when you drink alcohol (please circle):
Stuffy nose/nasal congestion  Runny nose  Shortness of breath  Wheezing

Environmental History
What type of home do you live in?  house  apartment  multifamily

Location of home:  city  suburb  rural

What kind of air control and heating does the home have? (Please circle your replies):
forced hot water  forced hot air  humidifier  room air conditioning
wood stove  dehumidifier  air filter  central air conditioning

What type of flooring does the bedroom have? (Please circle your replies):
hardwood floors  wall-to-wall carpeting  area rugs  tile/linoleum

Does the home have any pets?  Please list.

Does anyone smoke at home?  If so, who?

Family History (Please check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>asthma</th>
<th>hay fever</th>
<th>nasal polyps</th>
<th>immune deficiency</th>
<th>aspirin sensitivity</th>
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</thead>
<tbody>
<tr>
<td>Mother</td>
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<td>Father</td>
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<td>Other</td>
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Have you had any other serious illnesses, accidents, or hospitalizations?  If so, when?

Are you pregnant or planning on getting pregnant?
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Have you ever felt unsafe in the home or been afraid of anyone?  Yes  No

Do you feel pain as part of your daily life?  Yes  No
If yes, where do you feel pain?  How does the pain start?  How long does it last?  How would you describe it?

If yes, on a scale from 1-10, 10 being the greatest pain, which number better describes this pain?
If yes, how do you treat your pain?

Have you had any unexpected weight gain or loss in the past six months?  Yes  No

How do you like to learn new information?  □ Talking with your nurse or doctor  □ Reading

Have you fallen down within the past year?  Yes  No

Do you have a Health Care Proxy, Advance Directive, or Living Will?  Yes  No
If yes, please tell us his or her name:

The information on this form is accurate to the best of my knowledge. I understand that this form will become part of my medical record.

Patient Signature: ____________________________  ____________  ____________ AM/PM
Date  Time

I have reviewed the above information with the patient.

Comments: ____________________________________________________________

Reviewed by:  

-----------------------------------------------------  ____________  ____________ AM/PM
MD Signature  Date  Time