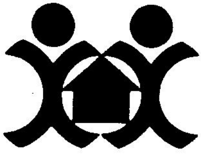

Boston Housing Authority
Occupancy Department
52 Chauncy Street, 3rd Floor
Boston, Massachusetts 02111-02375

617-988-3400
TDD 1-800-545-1833 Ext. 420

Asthma Questionnaire

(Request for More Information to Qualified Medical Provider Regarding Reasonable Accommodation for Asthma)

Head of Household: ____ **Client #:** _____________

Household Member Who Needs an Accommodation(s): _____________________________________

Address: ____**Unit #:** __________

Daytime Phone: (_____)______________________ **Cellular Phone: (_____)**_____________________

PLEASE PRINT CLEARLY

1. Does any Household Member have doctor-diagnosed asthma? **If more than one Household Member has doctor-diagnosed asthma, please fill out a separate Asthma Questionnaire form for each individual.**

   Yes. Please list name and age below:
   Name: ____ Age: __________
   No. **Skip to Question 10**.

2. Has this Household Member used an asthma medication during the last year?

   Yes. Please list the medication[s]:____
   ____
   No.

3. Is the Household Member's asthma only active in certain seasons?

   Yes. Please list season[s]:____)
   No.

4. What is the Asthma Severity for the Household Member? Please use NHLBI guidelines for severity.

   Mild Intermittent (day symptoms <2x/week, night symptoms <2x/month)
   Mild Persistent (day symptoms 3-6x/week, night symptoms >2x/month)
   Moderate Persistent (day symptoms every day, night symptoms >1x/week)
   Severe Persistent (day symptoms many times a day, night symptoms >2x/week)

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Household Member Who Needs Accommodation(s):______________________**Client #:**_________

5. What asthma/allergy medications are **currently** used by the Household Member? Please write in name(s) of medication(s) below and the frequency of use:

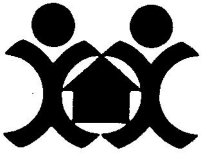
   Rescue medicine ____
   (Daytime: # times/week __________) (Nighttime: # times/week __________)
   Controller medicine: _________________ (# times/day__________)
   Controller medicine: _________________ (# times/day__________)
   Allergy medicine: ___________________ (# times/day__________)
   Other medicine: ____________________ (# times/day__________)
   Other medicine: ____________________ (# times/day__________)

6. For the past **12 months,** please indicate the **number** of times the Household Member has had asthma-related medical care in the below categories. Please indicate **zero or none** where applicable.
   ______Clinic visits ______Preventative/asthma checks
   ______Urgent care visits ______Emergency Room visits
   ______Hospitalizations ______Hospitalizations in the Intensive Care Unit

7. In your opinion, what conditions exist in this Household Member's home which are exacerbating the Household Member's asthma? Attach additional pages if necessary.
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

8. Does any Member or Guest of this Household smoke or have pets?
   Yes. Please provide details:____
   ____

   No.



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Household Member Who Needs Accommodation(s):______________________**Client #:**_________

9. Have you or a member of your staff visited this Household Member's home?

   Yes. When was your last visit(s)?: ____

   Please detail your observations. Attach additional pages if necessary. ___________________

   ____

   ____

   ____

   No.

10. **a)** Please provide detailed reason(s) why the current unit does not meet the Household Member's medical need(s); **b)** What changes to the current unit are necessary in order to meet the Household Member's medical need(s)?; **c)** If moving is required, please submit verification or evidence to document how and why the Household Member's health will improve **only** if moved from the current unit and what features are needed. (Be specific). Attach additional pages if necessary.

____

____

____

____

____

11. **a)** What actions have been taken by the physician, parent, and/or care provider to improve the medical condition? (i.e. allergen testing, changes in the current unit such as the use of air conditioner, air purifiers, hepa-filters, other allergen controls); and **b)** What is the Household Member's current and previous history in other environments? (i.e school, work, etc.) Attach additional pages if necessary.

____

____

____

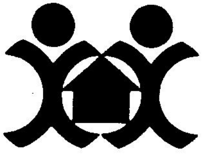
____

____

____

_________________________ _____________________________ ___________

Medical Provider's Signature Print Name Date



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______________________________ (______)__________________________

Agency Name Phone Number