APPENDIX B:

Sample Methacholine Challenge Pre-Test Questionnaire

First Name: _____ Last Name: _____

Date of Birth: _____

Medical Record or ID Number: _____

1. List all medications you have taken in the last 3 days for asthma, hay fever, heart disease, blood pressure, allergies, or stomach problems, and the number of hours or days since your last dose for each medication.

Name of Medication	Date and time of last treatment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Has a physician told you that you have asthma? Yes No
3. Have you ever been hospitalized for asthma? Yes No
4. Did you have recurrent episodes of cough and wheezing or lung infections as a child? Yes No
5. Have you experienced asthma symptoms such as wheezing or shortness of breath within the last two weeks? Yes No
6. If you are a smoker, when did you last smoke? _____
7. Have you had a respiratory infection in the last 6 weeks? Yes No
8. Have you had a heart attack or stroke within the last 3 months? Yes No
9. Do you have high blood pressure? Yes No
10. Do you have an aortic aneurysm? Yes No
11. Have you had recent eye surgery? Yes No
12. Are you pregnant or nursing? Yes No