UNITED STATES AIR FORCE SCHOOL OF AEROSPACE MEDICINE
Aeromedical Consult Services
Medical Flight Standards
Wright Patterson Air Force Base, Dayton, Ohio 45433

Asthma Questionnaire

Please provide all medical documents concerning this condition!	
Name:	SSN:
1. Have you ever been medically treated for a breathing problem? ➢ If yes, please explain (emergency room visits, hospitalizations, etc,)	
2. Have you ever had asthma, reactive airway disease, exercise induced bronchospasm, wheezing or shortness of breath? ➢ If yes, please explain (emergency room visits, hospitalizations, etc,)	
3. What age did it start?	
4. Date of last episode/attack?	
5. Date of last treatment or medication? Specify medication:	
6. PFT: YES: ☐ NO: ☐ Please provide documentation.	
7. Frequency of medication used: (e.g., daily, weekly, seasonal, prior to athletic/recreational activities, or as needed)	

By signing below, I certify that the above information is true and accurate to the best of my knowledge.

_____ _____

Applicant's Signature Date

Privacy Act Statement Authority: 5 USC §552a And Executive Order 9397**Purpose(s):** To determine medical acceptability or update a medical file as a part of the Flying Class I examination. **Routine uses:** This information may be disclosed to medical personnel engaged in the examination process. **Disclosure:** Voluntary; however, failure to furnish the requested information will impede the examination process and hamper your application. Use of Social Security Number (SSN) is used for positive identification of records.