



Dignity Health

Mercy Medical Center
Redding

Methacholine Challenge Pre-Test Questionnaire

First Name: _____ Last Name: _____

Date of Birth: _____

1. List all medications you are currently taking for asthma, hay fever, heart disease, blood pressure, and/or allergies.

Name of Medication	Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Has a physician told you that you have asthma? Yes No

3. Have you ever had a pulmonary function test? Yes No if yes, where? _____

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