QUEEN EDITH MEDICAL PRACTICE ASTHMA QUESTIONNAIRE

CONTACT DETAILS

NAME: **D.O.B:**

Address:

Home phone:

Mobile phone: **Do you consent to receiving text messages on this no? YES/NO**

Email:

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT FROM THE SURGERY REGARDING YOUR ASTHMA: Home telephone/Mobile phone text/email

ASTHMA QUESTIONNAIRE (Please circle as appropriate)

1. **When was your asthma diagnosed?**
   More than 10 years ago/Between 5-10yrs ago/less than 5yrs ago

2. **In the last month have you had any difficulty sleeping because of your asthma symptoms (including cough)? NO**

   YES- circle how often:

   every day/1-2 times a week/1-2 times per month/1-2 times a year.

3. **In the last month has your asthma interfered with your usual activities? YES/NO**

4. **In the last month have you had your usual asthma symptoms during the day? (e.g. cough, wheeze, chest tightness or breathlessness)**

   NO / YES- circle how often below:

   Every day/1-2 times a week/1-2 times in the month

5. **How often do you use your blue inhaler? Please circle how often:**

   Every day/1-2 times a week/1-2 times a month/Every few months/Annually

   Or other details……

IF YOU ARE USING YOUR BLUE INHALER 3 or more times a week PLEASE make an appointment

6. **Do you know what your usual best peak flow is YES/NO if yes please record value……**

7. **If you are using an inhaled steroid do you use it with a spacer? YES/NO**

8. **Do you smoke YES/NO**

If yes – would you like to be given further details of the 'Stop Smoking' services available? YES/NO

THANK YOU – PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE TO THE SURGERY