A S T H M A Q U E S T I O N A I R E

Please Complete & Return

Name: ……

Address: ……

…… Postcode: ……

Date of Birth:……Height:…… Weight: ……

Please complete the following questions regarding your asthma. This will help the doctors to see how well you asthma is controlled: -

1) Do you use your blue inhaler? 3 times a week [ ] Less [ ] More [ ]

2) Do you wake at night due to your asthma? Yes [ ] No [ ]

3) Do you have Asthma symptoms every day? Yes [ ] No [ ]

4) Do you have Asthma symptoms when walking, running or going up hills or stairs? Yes [ ] No [ ]

If you answered yes to one or more of the above questions then your asthma is probably not as well controlled as it might be. Please make an appointment with our Nurse or Doctor.

5) Do you take a peak flow measurement at home? Yes [ ] No [ ]

What was the last Peak Flow reading you took? _____

If **NOT** ask the receptionist for a Peak Flow to be done.

6) Do you smoke?

Non-Smoker [ ] Ex-Smoker [ ]

Current Smoker [ ] Trying to stop [ ] Need Advice [ ]

If you need help phone the QUIT SMOKING SERVICE on FREEPHONE 0800 085 6258

7) Have you had the Flu Vaccination? Yes [ ] No [ ]

If NO please make an appointment with the nurse.

Do you wish to be exempt form this year's annual review? Yes [ ] No [ ]

If YES please give your reason

……

……

Signature: …… Date: ……