StAMC

17. Asthma Annual Review Questionnaire

Surname		**First name**	
Home tel. number		**Mobile**	
D.O.B (dd/mm/yy)		**Email**	
Usual doctor (circle)		Cottrell/Robson/Riley/Mason/Rajagopal/Bruce	
When was your asthma diagnosed? (enter years)			
In the last month, have you had any difficulty sleeping because of your asthma symptoms (including cough)?		**Yes/No**	
Details of sleeping difficulties			
In the last month, have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?		**Yes/No**	
Details of symptoms during the day:			
How often do you use your blue inhaler?			
Details of inhaler use			
In the last month has your asthma interfered with your usual activities (e.g. housework, work, school etc)?		**Yes/No**	
Have you ever had your peak flow measured at the surgery?		**Yes/No**	
If 'Yes', what is your best PEFR value (enter ml/min)			
Are you happy with your inhaler technique?		**Yes/No**	
If 'No' see a **demonstration on the Asthma UK website** www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers or see our practice nurse for more advice			
Have you ever smoked?		**Yes/No**	
If 'Yes' do you smoke now'?		**Yes/No**	
If 'Yes' how many cigarettes do you smoke a day?			
If 'No' then did you quit (enter months/years)			
If you would like to **help to quit smoking** come to our stop smoking clinic here every Thursday. Book your place: on 0800 849 4444 or text quit to 87023			