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| ASTHMA QUESTIONNAIRE | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record.**All questions marked with an \* are compulsory** | | | | | | | | | | | | | | |
| Asthma Questionnaire | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | Click or tap here to enter text. | | |  | | DOB\* | |  | | | | | |
| E mail \* 🖂 | | | | | | | | | | | | | |  |
| Telephone number \* 🕿 Click or tap here to enter text. | | | | | | Mobile Number \* Click or tap here to enter text. | | | | | | | |  |
|  | | | | | | | | | | | | | | |
| PLEASE NOTE: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| This questionnaire is to review your asthma, and your practice might not see this report for up to 7 days. If you are having severe symptoms, please seek urgent assessment by calling your practice directly, or if closed call 111 or attend your local A&E department. *(please tick box that you understand the above statement).* | | | | | | | | | | | | | | |
| How often does your asthma cause symptoms during the DAY \* | | | | | | | | | | | | | | |
|  | Never | |  | 1-2 times per month | | |  | 1-2 times per week | |  | Most days | | | |
| **How often does your asthma cause symptoms during the NIGHT? \*** | | | | | | | | | | | | | | |
|  | Never | |  | 1-2 times per month | | |  | 1-2 times per week | |  | | Most days | | |
| How often does your asthma limit your activities? \* | | | | | | | | | | | | | | |
|  | Never | |  | 1-2 times per month | | |  | 1-2 times per week | |  | | | Most days | |
| **How many asthma exacerbations (attacks) have you had in the past year? \***  **Click or tap here to enter text.** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **How many times have you attended Accident and Emergency Department since your last asthma review? \* Click or tap here to enter text.** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **What inhalers do you use? If unsure of the name, please put the colour of it. \***  **Click or tap here to enter text.** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **How many times per day do you use your inhaler? \***  **Click or tap here to enter text.** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Asthma Control Test Score | | | | | | | | | | | | | | |
| **How often did your asthma prevent you from getting as much done at work / school home? \*** | | | | | | | | | | | | | | |
|  | | All of the time | |  | Most of the time | | |  | Some of the time | |  | None of the time | | | |
| **How often have you had shortness of breath?** | | | | | | | | | | | | | | | |
|  | | More than once a day | |  | Once a day | | |  | 1-2 times per week | |  | None at all | | | |
| **How often did your asthma symptoms wake you up at night or early in the morning?** | | | | | | | | | | | | | | | |
|  | | 4 or more times a week | |  | 2-3 nights a week | | |  | Once a week | |  | Not at all | | | |
| **How often have you used your reliever inhaler (usually blue)?** | | | | | | | | | | | | | | | |
|  | | 3 or more times a day | |  | 1-2 times a day | | |  | 2-3 times a week | |  | Not at all | | | |
| **How would you rate your asthma control?** | | | | | | | | | | | | | | | |
|  | | Not controlled | |  | Poorly controlled | | |  | Somewhat controlled | |  | Completely controlled | | | |
| **If you have a peak flow meter, what was your reading this week?** | | | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | | |

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| Lifestyle - Alcohol | | | | | | | | |
| **How often do you have a drink containing alcohol? \*** | | | | | | | | |
|  | 4 or more times a week |  | 2-3 times a week |  | 2-4 times a month |  | | Monthly or less |
|  | Never | | | | | | | |
| **How many units of alcohol do you drink on a typical day drinking? \*** | | | | | | | | |
|  | 0 |  | 1-2 |  | 3-4 |  | 5-6 | |
|  | 7-8 |  | 9-10 |  | 10+ | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| Lifestyle - Smoking | | | | | | |
| **Do you smoke? \*** | | | | | | |
|  | Never |  | Ex-smoker |  | Trivial smoker |  |
|  | Light smoker (1-9 cigarettes per day) | | |  | Moderate Smoker (10-19 cigarettes per day) | |
|  | Heavy smoker (20-39 cigarettes per day) | | |  | Heavy smoker (40-60 cigarettes per day) | |
| **Do you use an e-cigarette / Vape? \*** | | | | | | |
|  | Yes |  | No |  | Ex-user |  |
| **Are you exposed to cigarette smoke, for example at home or at work? \*** | | | | | | |
|  | Yes |  | No |  | | |

|  |
| --- |
| **Lifestyle - BMI** |
| **Tell us your weight (optional) Click or tap here to enter text.** |
| **Tell us your height (optional) Click or tap here to enter text.** |
|  |
| I consent to my information being used for the purpose described above and wish to submit this accurX form to Mickleover Medical Centre, Vicarage Road, Mickleover, DE3 0HA \* |