|  |
| --- |
| 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. |

|  |
| --- |
| 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+ |

|  |
| --- |
| 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 \* |