Name:
Date of Birth:

Date:

We are currently reviewing our Asthma Clinic and have noted that the medication you use requires us to review you once a year. We would be grateful therefore if you could answer the questions listed below ticking the appropriate boxes.

During the last 4 weeks:

1. Has your asthma interrupted your usual daytime activities or are you needing your Ventolin (blue inhaler) every day?

YES		**NO**	

2. Have you had difficulty sleeping because of coughing, wheezing or shortness of breath during the night?

YES		**NO**	

3. Have you suffered from an asthma related wheeze, cough, breathlessness or chest tightness during the day at least once this week?

YES		**NO**	

4. **For patients aged 13 years and over -** Are you a smoker? If yes, we offer a Smokestop Service - please contact reception for further information.

YES		**Cigarette / Pipe / Tobacco**		**Amount per day**	
EX-SMOKER		**Cigarette / Pipe / Tobacco**		**Amount per day**	
NEVER SMOKED					

Smoking cessation is strongly recommended in respiratory disease. This information is requested by the Department of Health.

5. What inhalers are you using regularly?
………………………………………………………………………………………...

………………………………………………………………………………………...

6. If you have a meter please record your PEAK FLOW in the box

Thank you for your co-operation and for taking the time to answer this questionnaire. All information will be treated with complete confidentiality. If your asthma appears not to be well controlled I will ring you to discuss.