**ASTHMA ANNUAL REVIEW QUESTIONNAIRE**

**PLEASE ONLY FILL IN THIS FORM IF YOU DO NOT WISH TO ATTEND THE SURGERY FOR YOUR ANNUAL REVIEW**

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**NAME:**

**ADDRESS:**

**DOB:**

**Have you had difficulty sleeping because of your asthma symptoms, including cough?**

 Disturbing Sleep If yes - how many times per week? ........

 Not Disturbing Sleep

Comment…………………………………………………………………………….

**Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?**

 No symptoms 1-2 per month 1-2 per week Most Days

Comment……………………………………………………………………………….

**Has your asthma interfered with your usual activities, eg housework, work, school?**

 Most Days 1-2 Month 1-2 Week Not Limiting

Comment………………………………………………………….…………………

 **Reliever Inhaler Use**

 I only use an inhaler when I get hayfever symptoms or a cold

 I use my inhaler infrequently (1-2 per month)

 I use my inhaler every week

 I use my inhaler every day

 I use an inhaler for symptoms and also to prevent symptoms happening

Comment………………………………………………………….…………………

**Smoking Status**

 Never Smoked Ex-Smoker Current Smoker

* If a smoker would you like to see our smoking cessation advisor for advice on stopping smoking and available drug therapy?

 Yes No

**BMI**

Height ………………………. Weight …………………

 I DO NOT want to attend an asthma review this year but I understand that if the doctor needs to review any of the answers I have given here that I may be asked to make an appointment. I understand that if I have a repeat medication I may have to have an appointment to have this reviewed this year.

Signed …………………………………………….. Date ………………

Please send to Victoria Road Surgery, 50 Victoria Road, Worthing, BN11 1XE