**ASTHMA Questionnaire**

1. In the last year has your asthma caused any daytime symptoms? Please tick.

|  |  |  |  |
| --- | --- | --- | --- |
| No | Yes most day | Yes 1-2 times per week | Yes 1-2 times per month |
|  |  |  |  |

1. In the last year has your asthma limited your daytime activities (including walking)? Please tick.

|  |  |  |  |
| --- | --- | --- | --- |
| No | Yes most day | Yes 1-2 times per week | Yes 1-2 times per month |
|  |  |  |  |

1. In the last year has your asthma disturbed your sleep? (including a cough) Please tick.

|  |  |  |
| --- | --- | --- |
| No | Yes most nights | Yes weekly |
|  |  |  |

1. Military Veteran? **YES/NO**

1. Has your asthma caused any hospital admissions in the last 12 months? **YES/NO**
2. Is your asthma medication controlling your symptoms? **YES/NO**
3. Would you like a flu vaccination? **YES/NO**
4. Smoking Status. Please tick / provide information

|  |  |  |
| --- | --- | --- |
| Never Smoked | Smoker | Ex Smoker |
|  | Number cigarettes per day |  |

If a smoker would you like smoking cessation advice? **YES/NO**

**We would advise all our patients to stop smoking.**

|  |  |  |
| --- | --- | --- |
| **Height** | **Weight** | **Blood Pressure** |
|  |  |  |

If you are unsure of the above, please use our Health Check Machine that is situated in Reception. In the future we would like to contact you either by Email or Text messaging, if this is acceptable please provide up to date information:

Email Address………………………………………….Mobile Phone Number…………..………………………

Name BLOCK CAPITALS………………………………………….DOB……………… Signed…………………….