LEIGH VIEW MEDICAL PRACTICE

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Patient Name:
Patient Date of Birth:
Patient NHS Number (if known):

Asthma Review

Please complete the following questions to allow your health care professional to assess your asthma. This questionnaire is for a routine review of your symptoms. If you are experiencing severe shortness of breath at present, please follow your care plan (if you have one) or ring your GP or 999 immediately.

Your Asthma

1. How often does your asthma cause symptoms during the day?

- ☐ Never
- ☐ 1 to 2 times per month
- ☐ 1 to 2 times per week
- ☐ Most days

2. How often does your asthma cause symptoms at night?

- ☐ Never
- ☐ 1 to 2 times per month
- ☐ 1 to 2 times per week
- ☐ Most nights

3. How often does your asthma limit your activities

- ☐ Never
- ☐ 1 to 2 times per month
- ☐ 1 to 2 times per week
- ☐ Most days

4. How many asthma exacerbations (attacks) have you had in the past year?

5. How many times have you attended Accident and Emergency Department since your last asthma review?

Inhaler Technique

It is essential to have a good inhaler technique to ensure that your medication gets to the part of your lungs that need it. Please watch the specific inhaler video below to check that you are using your inhalers correctly:
For further information, see: https://www.asthma.org.uk/advice/inhaler-videos/

1. I have watched the above relevant inhaler technique videos and am happy with my inhaler technique

☐ Yes ☐ No

Your Lifestyle – Smoking

Do you smoke?	☐ Never smoked	☐ Ex-smoker	☐ Yes		
Do you use an e-Cigarette?	☐ No	☐ Ex-User	☐ Yes		
How many cigarettes did/do you smoke a day?	☐ Less than one	☐ 1-9	☐ 10-19	☐ 20-39	☐ 40+
Would you like help to quit smoking?	☐ Yes	☐ No			

For further information, please see: www.nhs.uk/smokefree

Asthma Control Test Score

The Asthma Control Test provides a score to help you and your healthcare provider determine if your asthma symptoms are well controlled.
If you are 12 years or older, please complete the questions below.

1. How often did your asthma prevent you from getting as much done at work/school/home?

   - ☐ All the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ A little of the time
   - ☐ None of the time

2. How often have you had shortness of breath?

   - ☐ More than once a day
   - ☐ Once a day
   - ☐ 3-6 times a week
   - ☐ 1-2 times a week
   - ☐ None at all

3. How often did your asthma symptoms wake you up at night or early in the morning?

   - ☐ 4 of more times a week
   - ☐ 2-3 nights a week
   - ☐ Once a week
   - ☐ Once or twice
   - ☐ Not at all

4. 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
   - ☐ Once a week or less
   - ☐ Not at all

5. How would you rate your asthma control?

   - ☐ Not controlled
   - ☐ Poorly controlled
   - ☐ Somewhat controlled
   - ☐ Well controlled
   - ☐ Completely controlled

Further Questions

1. Do you have a written asthma care plan?

   - ☐ No
   - ☐ Yes and I am happy with it
   - ☐ Yes but I am not happy with it
   - ☐ Yes but I have lost it