ANNUAL ASTHMA CHECK

QUESTIONNAIRE

Name ____

Date Of Birth _______________________________________

Mobile Phone ______________________________________

Email ____

In the last month…	YES	NO
Have you had difficulty sleeping* because of your asthma symptoms (including cough)?		
Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?		
Has your asthma interfered with your usual activities (e.g. housework, work, school etc)?		
Have you used your reliever (usually blue) inhaler more than once or twice per week?		

(*Difficulty sleeping includes EVER waking at night or early in the morning to take your inhaler)

If you answered **YES to 1 question** you may benefit from a review, please arrange a telephone or face-to-face appointment with a nurse.

If you answered **YES to 2 or more questions** your asthma is not controlled. Please book a face-to-face review with a nurse. This is a review to help you manage your condition, review your medication, give you information and reduce the risks of complications including asthma attacks.

If you answered **NO to all 4 questions** this indicates good asthma control and we do not need to see you (unless you would like to be seen).

- **Please ALWAYS bring your inhalers to your review appointment.**

Please return this questionnaire to us at: ncccg.contact-gfmc@nhs.net ***and we will update your medical records.***

Review your inhaler technique at
www.asthma.org.uk/advice/inhaler-videos/

Further information and resources are available online at ASTHMA UK
www.asthma.org.uk

We may contact you via text or email about your answers to this questionnaire. If you do not wish to be contacted in this way please tick the box ☐