This form is used for your annual asthma review. Please complete the following questions to allow your health care professional to assess your asthma and submit to us on email – [mkccg.npmcmail@nhs.net](mailto:mkccg.npmcmail@nhs.net).

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), make an appointment with the Respiratory Nurse or GP via Klinik or call 999 immediately.

By using this form you will be sending information about yourself across the internet; whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantees of absolute privacy. If this matter concerns you then you should use another method to notify us of your information.

**Your Details**

Name: ………………………………………………………………………………………………

Date of birth: ………………………………………………………………..

Telephone number: ……………………………………………………………….

Email address: ……………………………………………………………….

**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 – Alcohol**

Please answer the following questions which are validated as screening tools for alcohol use:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT–C QUESTIONS** | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or Less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| A score of **less than 5** indicates *lower risk drinking* | | | | | **TOTAL:** |  |

**Scores of 5 or more** requires the following 7 questions to be completed:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **AUDIT QUESTIONS**  (after completing 3 AUDIT-C questions above) | **Scoring System** | | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | | **4** |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in last year |  | | Yes, during last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in last year |  | | Yes, during last year |  |
|  | | | | | **TOTAL:** | |  |
|  | | | | | | | |

**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 1 |  | 1-9 |  | 10-19 |  | 20-39 |  | 40+ | |
| Would you like help to quit smoking? | |  |  |  |  | | --- | --- | --- | --- | |  | Yes |  | No | |
|  |  | |

**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 or 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**

I have the following information, questions or concerns that I would like to raise with my Asthma Nurse or Doctor:

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please see the following links for further information on Asthma that you may find useful:

NHS Choices - <http://www.nhs.uk/conditions/asthma/Pages/Introduction.aspx>

Patient. Info - <http://patient.info/health/asthma-leaflet>

Asthma UK - <https://www.asthma.org.uk>

**Follow-Up**

When you are happy with all your above answers, please return this questionnaire to your GP practice.

Depending upon your answers and your other medical conditions, you will be contacted if you need to be seen in clinic for a further assessment. Should your symptoms change, please seek medical advice and book an appointment if required.