Our Ref: ...

Date ...

**PRIVATE AND CONFIDENTIAL**

Dear *...*

This questionnaire is designed to assess your asthma control and if you need a ‘face to face’ yearly review. The information that you submit will be analysed along with your care records and if there are any areas of concern, a member of the Practice will be in touch with you.

However, if you feel that your asthma is poorly controlled, you may wish to make an appointment with the Nurse or Nurse Practitioner rather than completing a questionnaire.

If all is well we may make an appointment in a years time but please contact us if you feel your asthma is worse at any time.

**If you do not complete or return the questionnaire a routine appointment will be sent automatically. So please respond accordingly or valuable appointments will be wasted.**

Please also find enclosed your personal asthma action plan which you need to complete and keep in a safe place for future reference. If you need any help completing this, please let us know.

If you are taking regular inhalers you are then eligible for an annual flu vaccine. These are bookable from **September** to **February** each year. Contact the surgery between these dates to arrange an appointment.

Yours sincerely

**Asthma Control Test score of 20-25 = ABOVE TARGET**

**-**Your Asthma appears to have been under control over the last 4 weeks.

**-**However, if you are experiencing any problems with your asthma, you should see your healthcare professional (e.g. Doctor, Nurse or Pharmacist).

**Asthma Control Test score of 15 or less = OFF TARGET**

-Your Asthma has not been controlled during the past 4 weeks.

-Make an appointment with your healthcare professional (e.g. Doctor, Nurse or Pharmacist) straight away to discuss what action is needed.

**Asthma Control Test score of 16-19 = ON TARGET**

-Your Asthma appears to have been reasonably well controlled during the past 4 weeks.

-However, if you are experiencing any problems with your asthma, you should see your healthcare professional (e.g. Doctor, Nurse or Pharmacist).

**Asthma Questionnaire**

To enable us to update your records, please complete this form and return to your GP surgery for the attention of Respiratory Admin Team.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  | | | | Date of Birth: |  | |
| Phone Number: | Home: |  | | | Mobile: |  | |
| EMIS Number | Office use only | | Height: |  | | Weight: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Asthma Control Test** | | | | | | | | | | | | | | |
| **Q1:** | During the **past 4 weeks**, how often did your Asthma prevent you from getting as much done at work, school or home? | | | | | | | | | | | | | |
|  | **1:** All of the time | **2:** Most of the Time | | | | **3:** Some of the time | | **4:** A little of the time | | **5:** None of the time | | | |  |
| **Q2:** | During the **past 4 weeks**, how often have you had shortness of breath? | | | | | | | | | | | | | |
|  | **1:** More than once a day | **2:** Once a day | | | | **3:** 3-6 Times a week | | **4:** 1-2 Times a week | | **5:** Not at all | | | |  |
| **Q3:** | During the **past 4 weeks**, how often did your Asthma symptoms (wheezing, coughing, shortness of breath, chest tightness) wake you up at night or earlier than usual in the morning? | | | | | | | | | | | | | |
|  | **1:** 4 or more times a week | **2:** 2-3 nights a week | | | | **3:** Once a week | | **4:** Once or twice | | **5:** Not at all | | | |  |
| **Q4:** | During the **past 4 weeks**, how often have you used your rescue inhaler  (Such as Salbutamol)? | | | | | | | | | | | | | |
|  | **1:** 1 or more times a day | **2:** 1 or 2 times a day | | | | **3:** 2 or 3 times week | | **4:** Once a week or less | | **5:** Not at all | | | |  |
| **Q5:** | How would you rate your Asthma control during the **past 4 week**? | | | | | | | | | | | | | |
|  | **1:** Not controlled | **2:** Poorly controlled | | | | **3:** Somewhat controlled | | **4:** Well controlled | | **5:** Completely  controlled | | | |  |
|  | | | | | | | | **Total:** | |  | | | | |
| **Are you confident you can use your inhaler correctly** | | | | | | | | | | | | | | |
| **YES** | | |  | **NO** | | | |  | **NEED HELP** | | | |  | |
| **Asthma Exacerbations** | | | | | | | | | | | | | | |
| Number of exacerbations in the past year resulting in the use of steroids and/or anti-biotics: | | | | | | | | | | | |  | | |
| **Peak Flow Score** | | | | | | | | | | | | | | |
| **A:** Peak flow rate before inhaler. | | | | |  | | **B:** peak flow rater after inhaler. | | | |  | | | |
| **If you do NOT have a peak flow meter at home, please notify the surgery and a prescription can be generated for you.** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |

**SMOKING STATUS:**

Do you smoke? Yes No

If Yes, how many cigarettes do you smoke per day ( ) OR per week ( )

OR How many cigars do you smoke per day ( ) OR per week ( )

OR How many ounces of tobacco per week ( )

If **NO,** please tick as appropriate **-** Never smoked Ex-smoker

How many did you smoke ( ) Date you stopped ( )

Have you been offered smoking cessation advice? Yes No

**If you would like advice, help and support regarding stopping smoking please contact Smokefreelife** Somerset on 01823 356222. Also most pharmacies will have a trained stop smoking advisor there to assist and advice.

Please provide any extra information that might help the team:

A few online websites that you might find useful for further information:

* Understanding asthma – www.asthma.org.uk/advice/understanding-asthma/
* What to do in an asthma attack – www.asthma.org.uk/advice/asthma-attacks/
* Help to manage your asthma – www.asthma.org.uk/advice/manage-your-asthma/
* How to use your inhaler – www.asthma.org.uk/advice/inhaler-videos/
* Tips and suggestions for looking after your mental health – www.nhs.uk/oneyou/every-mind-matters