Asthma Review Form

NAME	
DATE OF BIRTH	
ADDRESS	
IF YOU ATTEND SCHOOL, PLEASE STATE WHERE	

ASTHMA REVIEW	
1. Are your symptoms making you use your reliever inhaler (often blue) more than 3 times a week?	
2. Have you had difficulty sleeping because of your asthma symptoms?	
3. Have you had your usual asthma symptoms during the day (cough/wheeze/chest tightness or breathlessness)?	
4. Has your asthma interfered with your usual activities (e.g. housework, work/school etc)?	
5. Do you smoke? If you answered 'YES', how many per day?	
6. Does anyone in your household smoke?	
7. Have you ever been admitted to ICU due to asthma?	
8. Have you been admitted to hospital due to asthma in the past 12 months?	

The Practice Nurse will review your answers and you will be contacted if she feels that you require a follow up appointment.