The Ridgeway Surgery asthma questionnaire 2019/2020

**Name: Date of Birth:**

We would like to ask you 5 questions about your asthma so that we can keep our records up to date and make sure we are providing the best possible treatment

**Question 1: Daytime symptoms. Does your asthma cause daytime symptoms…**

|  |  |
| --- | --- |
|  | Please tick one option |
| Never  |  |
| 1-2 times per month |  |
| Once or twice a week |  |
| Most days |  |
| Any other pattern (please specify) |  |

**Question 2: Exercise/physical exertion. Does your asthma…..**

|  |  |
| --- | --- |
|  | Please tick options that apply |
| Not limit physical activities |  |
| Increase exercise wheeze |  |
| Restrict exercise |  |
| Any other pattern (please specify) |  |

**Question 3: Sleep patterns. Does your asthma….**

|  |  |
| --- | --- |
|  | Please tick one option |
| Not disturb sleep |  |
| Disturbs sleep 1-2 times per month |  |
| Disturbs sleep 1-2 times per week |  |
| Disturbs sleep most nights |  |
| Any other pattern (please specify) |  |

**Question 4: Smoking status. Do you….**

|  |  |
| --- | --- |
|  | Please tick one option |
| Never smoked |  |
| Ex-smoker (please specify year) |  |
| Current smoker (specify number per day) (if current smoker, please answer question 5) |  |

**Question 5: Quitting smoking. Are you….**

|  |  |
| --- | --- |
|  | Please tick one option |
| Interested in support with quitting (one of our clinicians will contact you) |  |
| Not interested in support with quitting currently  |  |

**FOA Carole Lavery**