## **Asthma Annual Review**

**If you have been advised by the surgery to submit an annual review of your asthma symptoms please use this form. If your symptoms are deteriorating or you are having any concerns please make an appointment with our Nurse.**

**Personal Details (fields marked with a red asterisk are compulsory)**

**Name \*** …………………………………………………………………………………………………………………………………………………………………. **Date of Birth (DD/MM/YYYY) \*** …………………………………………………………………………………………………………………………………………………………………. **Daytime Telephone** \* …………………………………………………………………………………………………………………………………………………………………. **Email (by providing your email address we assume consent to reply via email when necessary. If you prefer not to receive email, please alert the surgery)\*** …………………………………………………………………………………………………………………………………………………………………. **Gender**

………………………………………………………………………………………………………………………………...................................

**Postcode \*** ………………………………………………………………………………………………………………………………………………………………….

**Your Asthma Review**

**In the last month have you had difficulty sleeping due to your asthma (including cough) YES/NO**

**Have you had your usual asthma symptoms (e.g., cough, wheeze, chest tightness, shortness of breath) during the day? YES/NO**

**Has your asthma interfered with your usual daily activities (e.g., school, work, housework)? YES/NO**

**How often do you need to use your reliever inhaler? ……………………………………………………………………….**

**Since your last review, have you needed to see a doctor as an emergency or attend the A&E**

**department of a hospital as a result of your asthma? YES/NO**

 **If you replied ‘Yes’ to the last question please give additional details ………………………………………………….**

**……………………………………………………………………………………………………………………………………………………………..**

**Since your last review, have you needed a course of steroid tablets to get your asthma under control?**

 **YES/NO**

**Do you smoke? YES/NO**

**If you replied ‘Yes’, how often/how many? ............................................................................................**

**Do you want to quit? YES/NO**

**Which of these applies to you? EX-SMOKER/NEVER SMOKED**

**Did you have a flu vaccination last flu season? YES/NO**

**Please list the inhalers you use daily or on a regular basis (name/strength/how many puffs/how many times a day/via a space device?)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of inhaler** | **Strength** | **Number of puffs** | **How many times a day?** | **Via a space device?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***Privacy Protection***

*Information submitted these forms is used only for the purposes of processing your request. We may be in touch with you in relation to the information submitted.*

*Our practice has a strict confidentiality policy.*

*This information is not shared with any third party organizations. This information is retained for up to 28 days.*

**If you have any queries, please contact us:**

**Partington Family Practice, Central Road, Partington, Manchester M31 4FY.**

**Tel: 0161 775 7033 Fax: 0161 775 8411**

**Email:****clinical.partingtonfamily@nhs.net****​​ Twitter: @PartingtonFP**