



# Bow and North Tawton Medical Practices

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<b>During the <u>last 4 weeks</u>, how much of the time has your asthma kept you from getting as much done at work, school or home?</b>	(Please circle)	All of the time Most of the time Some of the time A little of the time None of the time
<b>During the <u>last 4 weeks</u>, how often have you had shortness of breath?</b>	(Please circle)	More than once a day Once a day 3-6 times a week Once or twice a week Not at all
<b>During the <u>last 4 weeks</u>, how often have your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) woken you up at night or earlier than usual in the morning?</b>	(Please circle)	4 or more nights a week 2 – 3 nights a week Once a week Once or twice Not at all
<b>During the <u>last 4 weeks</u>, how often have you used your rescue inhaler or nebuliser medication (such as Salbutamol)?</b>	(Please circle)	3 or more times a day Once or twice per day 2 – 3 times per week Once a week or less Not at all
<b>How would you rate your asthma control during the <u>last 4 weeks</u>?</b>	(Please circle)	Not controlled at all Poorly controlled Somewhat controlled Well controlled Completely controlled
<b>Do you take your preventer inhaler?</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
If yes, which statement best describes how you take this medicine now?	(please circle)	I take it everyday I take it some days, but not everyday I used to take it but now I do not I never take it
<b>Do you get a sore mouth or dry throat due to your inhalers?</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
If yes, do you rinse your mouth out after using the inhaler?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b>What is your current peak flow? (if you measure it)</b>		
<b>Are you happy with your inhaler technique?</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b><i>If you are not, did you know there is an online demonstration on <a href="http://theAsthmaUK.com">the Asthma UK website</a></i></b>		
<b>Do you SMOKE?</b>		
<b>Yes</b> <input type="checkbox"/> I <b>currently</b> smoke ..... cigarettes PER DAY		
<b>No</b> <input type="checkbox"/> However, I <b>previously</b> smoked ..... cigarettes per day but stopped ..... years ago		
<b>No</b> <input type="checkbox"/> I <b>have never smoked</b>		
<b>Your height:</b>	<b>Your weight:</b>	
<b>Thank you for taking the time to complete this form, please return to the practice.</b>		