MOORLAND MEDICAL CENTRE

Asthma Questionnaire

Name: DOB:]

1. Have you had difficulty sleeping because of your asthma symptoms (including coughing)?

   YES NO (Please circle)

2. Have you had unusual asthma symptoms during the day (cough, wheeze, tight chest or feeling breathless)?

   YES NO (Please circle)

3. Has your asthma interfered with your usual activities (housework, work or school)?

   YES NO (Please circle)

   If you have answered YES to any of the above questions, please contact the surgery to make an appointment with Andrea Birchall.

4. Smoking History

   Never smoked Past Smoker Current Smoker

   ……Daily

   If you are a current smoker and would like help to stop, please contact the surgery to make an appointment in the smoking clinic with Liz Knobbs or Alicia Rutter for advice on how to quit.

   This questionnaire can also be completed on line via our website; on www.moorlandmedicalcentre.co.uk