**HUNTCLIFF SURGERY**

**Name**:………………………………………………………………………………………………………………

**Date of Birth……………………………………………………………………………………………….**

**Address**:…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….……………………………………………………………………………

**Date of Asthma diagnosis**:……………………………………………………………………………….......................

**Do you smoke? Never / Current / Ex-smoker** (delete as necessary)

In the last month:

1. Have you had difficulty sleeping because of your asthma symptoms including cough? **YES/NO**
2. Have you had your usual symptoms (e.g. cough, wheeze, chest tightness, shortness of breath) during the day? **YES/NO**
3. Has your asthma interfered with your usual daily activities? (e.g. school/work/housework) **YES/NO**

**If you have answered yes** to any of these questions we would recommendthat you make a 15 minute appointment Anthea, Practice Nurse.

If you have any other concerns either currently or in the coming year regarding your asthma or inhalers we would urge you to make an appointment with Anthea, Practice Nurse

**Please hand this completed form in to the practice reception staff so that it can be forwarded to Anthea, Practice Nurse**