DR P DAS GUPTA

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**About You**

Full Name **\***

Please include all your given names.

### Date of Birth \*

Please use this date format: DD/MM/YYYY.

### Email Address \*

Please ensure that your email address is correct as this is how you will be notified of a reply.

**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?

NEVER 1-2 TIMES A MONTH 1-2 TIMES A WEEK 1-2 TIMES A DAY

2+ TIMES A DAY

Since your last review, have you needed to see a doctor as an emergency or attended the A&E department of a hospital as a result of your asthma?

YES NO

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

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?)

Please note that the details you give will be used to update your medical records.