Optimising Asthma Control Audit

Patient Asthma Questionnaire

Produced by Dr Mark L Levy (based on the GINA Asthma Control Tool www.ginasthma.org) for use with online Medical Audit at www.guideline.audit.com

How well is your asthma controlled?

Please

1. Fill in the details on the right
2. Answer Questions 1-4 by ticking the box next to your answer.
3. Do not leave any questions unanswered.
4. Follow the instructions for Question 5.
5. Return you completed form to your doctor/nurse.

First name: _____

Last name: _____

Date: _____

1. In the past week during the day, have you had any symptoms of your asthma such as wheezing, chest tightness or shortness of breath? If so, how many times?

□ No: not at all □ Yes: once or twice □ Yes: more than twice

2. In the past week, have you been wakened at night by any symptoms of your asthma such as wheezing, chest tightness or shortness of breath?

□ Yes □ No

3. In the past week, have your activities at home, work (or school), or exercise been limited by your breathing?

□ Yes □ No

4. How often have you had to use your rescue or reliever inhaler in the past week?

□ No: not at all □ Yes: one or two times □ Yes: more than twice

5. How much does your asthma bother you?

Not at all **Very much**

0 **10**

Please mark the horizontal line above with a vertical line to show how much your asthma bothers you. For example: