

**Asthma review for children aged four to eleven years**



Please use the form below if your child’s asthma is stable and controlled. If your child’s symptoms are deteriorating or you have any concerns, please make an appointment with the respiratory nurse or a doctor.

**Part 1. Please let your child respond to the first four questions (numbers 1 to 4). If your child needs help in reading or understanding the question, you may help, but let your child select the response.**

**Part 2. Complete the remaining questions on your own and without letting your child’s responses influence your answers. There are no right or wrong answers.**

Please email your completed form to us at [reception.harbourside@nhs.net](mailto:reception.harbourside@nhs.net) or deliver it to the surgery. We have a post box on the outside wall to the left of the main reception doors.

It is really important your child has good oral hygiene with inhaler use. If you are not sure about this, please ask.

**If your child is using a blue or reliever inhaler more than THREE times a week on a regular basis, please book a review with one of our respiratory nurses.**

**Note if returning the form by email:** Please note that you will be sending information about your child across the Internet. We use a secure email service. Whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantee of absolute privacy. If this matter concerns you then please print off the form, complete it and return to the surgery.

**Personal Information:** Personal information retained on this system is stored in a secure data centre located in the UK and is treated as confidential.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | |
| **ASTHMA REVIEW QUESTIONNAIRE** **For children aged 4 to 11 years** All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | |
| Name |  | | |  | Date of birth: | | | |
| **Home Phone:** | | |  | | **Mobile phone:** | | | |
| Email address: | | | | | | | | |
| Address: | |  | | | Postcode: | |  | |
|  | | | | | | | | |
| Please complete with as much detail as possible | | | | | | | | |
| *For your child to complete*How is your asthma today? | | | | | Very bad | | | |
| Bad | | | |
| Good  Very good | | | |
|  | | | | | | | | |
| *For your child to complete*  1. **How much of a problem is your asthma when you run, exercise or play sports?** | | | | | It’s a big problem, I can’t do what I want to do. | | | |
| It’s a problem and I don’t like it | | | |
| It’s a bit of a problem but it’s okay | | | |
|  | | | | | It’s not a problem | | | |
|  | | | | | | | | |
| *For your child to complete*  1. **Does your asthma make you cough?** | | | | | Yes all the time | | | |
| Yes, most of the time | | | |
| Yes, sometimes  No, never | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| *For your child to complete*  1. **Does your asthma make you wake up during the night?** | | | | | Yes, all the time | | | |
| Yes, most of the time  Yes, sometimes  No, never | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | | | |
| 1. **During the last four weeks how many days did your child have any daytime asthma symptoms?** | | | | | None | | | | | |
| 1 to 3 days | | | | | |
| 4 to 10 days | | | | | |
| 11 to 18 days | | | | | |
| 19 to 24 days  Every day | | | | | |
|  | | | | | | | | | | |
| 1. **During the last four weeks how many days did your child wheeze during the day because of asthma?** | | | | | None | | | | | |
| 1 to 3 days | | | | | |
| 4 to 10 days | | | | | |
| 11 to 18 days | | | | | |
| 19 to 24 days  Every day | | | | | |
|  | | | | | | | | | | |
| 1. **During the last four weeks how many days did your child wake up during the night because of asthma?** | | | | | None | | | | | |
| 1 to 3 days | | | | | |
| 4 to 10 days | | | | | |
| 11 to 18 days | | | | | |
| 19 to 24 days  Every day | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. **Does your child take their inhaler as prescribed?** | | | | |  | Yes  No | | | |
| For advice on how to use an inhaler please visit the Asthma UK website. Go to: <https://www.asthma.org.uk/advice/inhaler-videos/>  Alternatively ask at your pharmacy.  Correct inhaler technique is very important in the management of your asthma. | | | | | | | | | | |
| 1. **Has your child had any asthma exacerbations or attended A& E with asthma in the last 12 months?** | | | | |  | | | | | |
| No  Yes. If yes, how many? …… | | | | | |
| If you know it, please give us your child’s best peak flow reading from home. | | | | | Best peak flow reading is: | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. **Has your child had this year’s seasonal flu jab?** | | | | | No | | | Yes | | |
| If no, please contact the surgery to book an appointment. Flu vaccinations are available annually, between September & March.  I decline a flu vaccination for 2020/21. | | | | | | | | | | |
| 1. **Do you have a written asthma action plan for your child? Yes ……. No ………..** | | | | | | | | | | |
|  | | | | | | | | | | |