Asthma questionnaire

For asthma, wheeze or cough that may be linked to allergy.

Please type your answers into this form (or print and fill it in), save it, and email it to **referrals@vidamedical.com.au** at least **7 days before your appointment**. Skip anything that doesn't apply. If you are completing this for a child, answer for the child.

About you

Full name

Date of birth

Today's date

Phone and email

Completed by (if not the patient)

Usual GP and clinic

Your asthma

Has a doctor diagnosed you with asthma? ☐ Yes ☐ No ☐ Unsure

Age symptoms started

What sets off your symptoms?

- ☐ Colds or flu
- ☐ Pollen or spring
- ☐ Pets
- ☐ Aspirin or ibuprofen
- ☐ Exercise
- ☐ Thunderstorms
- ☐ Smoke
- ☐ Stress
- ☐ Cold air
- ☐ Dust
- ☐ Certain foods
- ☐ Not sure

Asthma symptom control: past 4 weeks

These questions follow the symptom control assessment in the Australian Asthma Handbook and GINA.

Daytime asthma symptoms (cough, wheeze, tight chest, breathlessness) on more than 2 days a week? ☐ Yes ☐ No ☐ Unsure

Woken at night by asthma, even once? ☐ Yes ☐ No ☐ Unsure

Needed your reliever on more than 2 days a week? (Don't count doses taken before exercise.) ☐ Yes ☐ No ☐ Unsure

Any activity limited by asthma? ☐ Yes ☐ No ☐ Unsure

Clinic use: 0 Yes answers = well controlled; 1 to 2 = partly controlled; 3 to 4 = poorly controlled.

Clinic use: number of Yes answers and control level

Asthma Control Questionnaire (ACQ)

Please also complete the Asthma Control Questionnaire online at asthma.org.au/acq-start (Asthma Australia). Write your score below or bring the result.

My ACQ score and date completed

Past year

Courses of oral steroids (e.g. prednisolone) in the past 12 months

ED visits or hospital stays for asthma in the past 12 months

Have you ever been in intensive care for asthma? ☐ Yes ☐ No ☐ Unsure

Your inhalers

Inhaler	Name	How often?	Use a spacer?
Reliever			
Preventer			
Other			

Do you have a written asthma action plan? ☐ Yes ☐ No ☐ Unsure

Do you smoke or vape? ☐ Yes ☐ No ☐ Unsure

Please keep taking your asthma medicines before your appointment.

Medicines

All medicines you take, including sprays, creams, vitamins and supplements

Do you take any of these?

☐ Antihistamines (e.g. Telfast, Zyrtec, Claratyne)
☐ Blood pressure or heart medicines
☐ Regular ibuprofen or aspirin
☐ Adrenaline autoinjector (EpiPen / Anapen)

Autoinjector expiry date (if you have one)

Family history

Does a parent, brother or sister have:

☐ Food allergy ☐ Eczema ☐ Asthma
☐ Hay fever ☐ Hives ☐ Not sure

Your goals

What would you most like to get out of this appointment?

Previous allergy tests, spirometry or FeNO (type, date, result). Please bring copies if available.

Before you arrive

Medicines: antihistamines and some other medicines can affect allergy testing. We'll email you instructions on which to pause and when. **Keep taking your asthma medicines.**

Bring: previous test results, photos of any reactions, and your adrenaline autoinjector if you have one.

Your information is confidential and stored in your medical record in line with our privacy policy.