

Name:	Acct. No:
Age:	DOB:
Phone:	PC:
Date:	Clinician:

## Take the Asthma Control Test™ (ACT) for people 12 yrs and older.

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for your total.

Step 3 Talk to your doctor about your score.

1. In the past <b>4 weeks</b> , how much of the time did your <b>asthma</b> keep you from getting as much done at work, school or at home?	All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	None of the time (5)	SCORE <input type="text"/>
2. During the past <b>4 weeks</b> , how often have you had shortness of breath?	More than once a day (1)	Once a day (2)	3 to 6 times a week (3)	Once or twice a week (4)	Not at all (5)	<input type="text"/>
3. During the past <b>4 weeks</b> , how often did your <b>asthma</b> symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	4 or more nights a week (1)	2 or 3 nights a week (2)	Once a week (3)	Once or twice (4)	Not at all (5)	<input type="text"/>
4. During the past <b>4 weeks</b> , how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	3 or more times per day (1)	1 or 2 times per day (2)	2 or 3 times per week (3)	Once a week or less (4)	Not at all (5)	<input type="text"/>
5. How would you rate your <b>asthma</b> control during the <b>past 4 weeks</b> ?	Not controlled at all (1)	Poorly controlled (2)	Somewhat controlled (3)	Well controlled (4)	Completely controlled (5)	<input type="text"/>
						TOTAL <input type="text"/>

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**If your score is 19 or less, your asthma may not be controlled as well as it could be.**