PULMONARY AND SLEEP ASSOCIATES OF MARIN

PATIENT NAME:

TODAY'S DATE:

DATE OF BIRTH:

Asthma Control Test®

This survey was designed to help you describe your asthma and how your asthma affects how you feel and what you are able to do. To complete it, please mark an X in the box that best describes your answer.

1. In the **past 4 weeks**, how much of the time did your asthma keep you from getting as much done at work or at home?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

2. During the **past 4 weeks**, how often have you had shortness of breath?

More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all
◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

3. In the **past 4 weeks**, how often did your asthma 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	2 to 3 nights a week	Once a week	Once or twice	Not at all
◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

4. In the **past 4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as Albuterol, Ventolin®, Proventil®, Maxair®, or Primatene Mist®)?

3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all
◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

5. How would you rate your asthma control during the **past 4 weeks**?

Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completey controlled
◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

TOTAL SCORE: 0