Patient Name: _____ Today's Date: _____

Date of Birth: _____

FOR PATIENTS:

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

Know your score. Share your results with your doctor.

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

Step 2 Add the score boxes for your total.

Step 3 Take the test to the doctor to talk about your score.

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school 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. During 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 or 3 nights a week	Once a week	Once or twice	Not at all
1	2	3	4	5

4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

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	Completely controlled
1	2	3	4	5

SCORE

TOTAL

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

FOR PHYSICIANS:

The ACT is:

- A simple, 5-question tool that is self-administered by the patient
- Clinically validated by specialist assessment and spirometry[1]
- Recognized by the National Institutes of Health

Reference: 1. Nathan RA et al. *J Allergy Clin Immunol.* 2004;113:59-65.

PEDIATRIC CARE NETWORK
Children's Hospital Colorado

ASTHMA DATA COLLECTION FORM

Please complete the following section:

1. Have you visited the Emergency Room or Urgent Care due to **asthma** in the last 6 months?
   ☐ Yes ☐ No
2. Have you been admitted to the hospital due to **asthma** in the last 6 months?
   ☐ Yes ☐ No
3. How many days of work (if applicable) have you missed due to your **asthma** in the last 6 months? ☐
4. How many days of school (if applicable) have you missed due to **asthma** in the last 6 months? ☐
5. Do you have frequent or seasonal allergy symptoms (running nose, nose rubbing, sneezing, itchy/watering eyes)? ☐ Yes ☐ No
6. Have you been prescribed a **daily controller asthma medication?**

   Examples of daily controller asthma medicines include: Advair, Asmanex, Budesonide, Dulera, Flovent, QVAR, Pulmicort, Singulair, Symbicort

   ☐ Yes (if Yes, go to 6a.) ☐ No (if No, go to 7.)

   a. How often do you **forget or miss** your **daily** controller asthma medicine?
      ☐ I am not supposed to take a daily asthma medicine
      ☐ None of the time
      ☐ Some of the time 1-2 days/week
      ☐ Most of the time 3-4 days/week
      ☐ All of the time 5-7 days/week
7. Have you received a flu vaccine (flu shot) in the last year?
   ☐ Yes ☐ No ☐ I don't know
   a. If **yes**, what date **(month and year)** did you receive the flu vaccine? _____/_____

Please Take the Asthma Control Test ™

Total Score ☐

Asthma Control Test on other side of page