Patient Name: _____ Date of Birth: _____

Your best daytime contact number: _____

Can we leave a message? Yes/No

Asthma Control Test™

Q1	During the last four weeks, how often did your asthma prevent you from getting as much done at work, school or 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
Q2	During the last 4 weeks how often have you had shortness of breath?	More than once a day 1	Once a day 2	3-6 times a week 3	1-2 times a week 4	Not at all 5
Q3	During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, chest tightness, shortness of breath) wake you up at night or earlier than usual in the morning?	4 or more times a week 1	2-3 times a week 2	Once a week 3	Once or twice 4	Not at all 5
Q4	During the past 4 weeks, how often have you used your reliever inhaler (usually blue)?	3 or more times a day 1	1-2 times per day 2	2-3 times per week 3	Once a week or less 4	Not at all 5
Q5	How would you rate your asthma control during the last 4 weeks?	Not controlled 1	Poorly controlled 2	Somewhat controlled 3	Well controlled 4	Completely controlled 5

In addition to the above, it will help us to assess your asthma control by answering the following questions:

Do you Smoke?

Yes _____ per day

Never

I used to smoke but I gave up in _____ (year)

If you have a peak flow meter device at home, please let us have a peak flow reading

_____

If you do not have a peak flow meter, would you like one? (if yes, we will arrange for a prescription to be issued)

Yes No

Continued overleaf/

Do you have any other concerns about your asthma control at the moment? (please tell us about them below)

Please return your completed questionnaire in the stamped addressed envelope provided.

Office Use Only

ACT Score:

Full review?

Short review?

Coded?

Patient Contacted?