| Patient Name: | Date of Birth: |
|-----------------------------------|----------------|
| Your best daytime contact number: | |
| Can we leave a message? Yes/No | |

| (SA | |
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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 | 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 | Once a day 2 | 3-6 times a week | 1-2 times a week | Not at all |
| 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 | 2-3 times a week | Once a week | Once or twice | Not at all |
| Q4 | During the past 4 weeks, how often have you used your reliever inhaler (usually blue)? | 3 or more times a day | 1-2 times per day | 2-3 times per week | Once a week or less 4 | Not at all |
| 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 |

| | | | 1 | 2 | 3 | 4 | 3 |
|-------|--------------------------|------------------|----------------|------------|----------------|------------------|------------------|
| In ad | ldition to the above, it | will help us to | assess your a | asthma co | ontrol by answ | vering the follo | owing questions: |
| Do y | ou Smoke? | Yes Neve | er | | per day | | |
| | | | ed to smoke l | (| year) | | |
| If yo | u have a peak flow me | ter device at ho | ome, please l | et us hav | e a peak flow | reading | |
| | | | | | | | |
| If yo | u do not have a peak fl | low meter, wou | ıld you like o | one? (if y | es, we will ar | range for a pre | escription to be |

Yes No

| Do you have any other concerns about your asthma control at the moment? (please tell us about them below) |
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| Please return your completed questionnaire in the stamped addressed envelope provided. |
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| Off II Ol |
| Office Use Only ACT Score: |
| Full review? |
| Short review? |
| Coded? |
| Patient Contacted? |
| |