

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, mark an (X) in the circle that best describes your answer.

To score the ACT: Answer each question and write the answer number in the box to the right of each question. Add your answers and write your total score in the **TOTAL** box shown below. Discuss the results with your doctor.

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 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 ☐
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2. During the past **4 weeks**, 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 ☐
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3. During the past **4 weeks**, how often did your asthma symptoms (wheezing, coughing, shortness of breath, tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	1 ☐	2 to 3 nights a week	2 ☐	Once or twice	3 ☐	Once a week	4 ☐	Not at all	5 ☐
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4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication?

3 or more times per day	1 ☐	1 or 2 times per day	2 ☐	2 to 3 times a week	3 ☐	Once a week or less	4 ☐	Not at all	5 ☐
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5. How would you rate your asthma control during the past **4 weeks**?

Not controlled at all	1 ☐	Poorly controlled	2 ☐	Somewhat controlled	3 ☐	Well controlled	4 ☐	Completely controlled	5 ☐
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SCORE

TOTAL

19
or less

If your score is 19 or less, it may be a sign your asthma is not controlled as well as it could be. No matter what the score, bring this test to your doctor to talk about your results.

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