Asthma Control Test

Please complete the following questions before you see the doctor / nurse

Read each question carefully and choose one answer for each question

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | During the **past 4 weeks**, how often did asthma prevent your child getting as much done at school or home? | | | | | | | | | |
| All the time | Most of the time | | | Some of the time | | A little of the time | | None of the time |  |
|  |  | |  |  | |  | |  | |  |
| 2 | During the **past 4 weeks**, how often has your child had shortness of breath? | | | | | | | | | |
| More than once a day | Once a day | | | 3-6 times per week | | 1-2 times per week | | Not at all |  |
|  |  | |  |  | |  | |  | |  |
| 3 | During the past **4 weeks**, how often did their asthma symptoms (wheeze, cough, tightness, short of breath) wake them at night or early in the morning? | | | | | | | | | |
| 4 or more times per week | 2-3 nights per week | | | Once per week | | Once or twice | | Not at all |  |
|  |  | |  |  | |  | |  | |  |
| 4 | During the past **4 weeks**, how often have they had to use their blue inhaler? | | | | | | | | | |
| 3 or more times per day | 1-2 times per day | | | 2-3 times per week | | Once per week or less | | Not at all |  |
|  |  | |  |  | |  | |  | |  |
| 5 | How would you rate their asthma control during the **past 4 weeks**? | | | | | | | | | |
| Not controlled | Poorly controlled | | | Somewhat controlled | | Well controlled | | Completely controlled |  |
|  |  |  | | |  | |  | |  |  |
|  |  |  | | |  | |  | | TOTAL |  |