

Enter Name \_\_\_\_\_

Enter Address \_\_\_\_\_

Enter City/State/Zip \_\_\_\_\_

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

## 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	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, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	1	2 or 3 nights a week	2	Once a week	3	Once or twice	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 (such as albuterol)?

3 or more times per day	1	1 or 2 times per day	2	2 or 3 times per 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**

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**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<sup>1</sup>
- Recognized by the National Institutes of Health