The Institute for Respiratory and Sleep Medicine

Asthma Control Test (ACT)
Date: ____/____/_____

Name:_____ Date of birth:___/___/___

Answer each question and circle the number in the box.

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	Most of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5

2. **During the past 4 weeks, how often have you had shortness of breath?**

More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all
1	2	3	4	5

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 to 2 times per day	Once a week	Once or twice	Not at all
1	2	3	4	5

4. **During the past 4 weeks, how often have you used your rescue inhaler or nebulizer machine? (such as albuterol)**

3 or more times per day	1-2 times per day	2-3 times per week	Once a week or less	Not at all
1	2	3	4	5

5. **How would you rate your asthma control during the past 4 weeks?**

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

TOTAL: _____

A SCORE OF 20 OR MORE SUGGESTS YOUR ASTHMA MAY BE WELL CONTROLLED.
A SCORE OF 19 OR LESS SUGGESTS YOUR ASTHMA MAY NOT BE WELL CONTROLLED.

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