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.

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	
2. During the	past <b>4 we</b> o	<b>eks</b> , how often	have you l	had shortness o	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	
_		,	•	thma symptoms ual in the morn		g, coughing, sho	ortness of	breath, chest	tightness	
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	
<b>4.</b> During the	past <b>4 we</b>	<b>eks</b> , how often	have you	used your rescu	ıe inhaler	or nebulizer me	dication	(such as albu	terol)?	
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	
<b>5.</b> How would	you rate yo	our <b>asthma</b> cor	trol durin	g the <b>past 4 we</b>	eks?					
Not controlle at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5	
										TOTAL

## 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
- Recognized by the National Institutes of Health
- Clinically validated by specialist assessment and spirometry<sup>1</sup>