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 |  |