USE "√ " IN CIRCLE TO INDICATE YOUR

ASTHMA CONTROL TEST
AGES 5+

TO BE COMPLETED BY PARENT OR PATIENT

Patient Name_____Date of Birth_____ **Today's Date_____**

1. How much of the time did asthma keep you from getting as much done at work, school or home?

IN THE PAST 4 WEEKS:	(1) ALL OF THE TIME	(2) MOST OF THE TIME	(3) SOME OF THE TIME	(4) A LITTLE OF THE TIME	(5) NONE OF THE TIME	☐
IN THE PAST 6 MONTHS:	(1) ALL OF THE TIME	(2) MOST OF THE TIME	(3) SOME OF THE TIME	(4) A LITTLE OF THE TIME	(5) NONE OF THE TIME	☐

2. How often have you had shortness of breath?

IN THE PAST 4 WEEKS:	(1) MORE THAN ONCE A DAY	(2) ONCE A DAY	(3) 3-6 TIMES/WEEK	(4) ONCE OR TWICE/WEEK	(5) NOT AT ALL	☐
IN THE PAST 6 MONTHS:	(1) MORE THAN ONCE A DAY	(2) ONCE A DAY	(3) 3-6 TIMES/WEEK	(4) ONCE OR TWICE/WEEK	(5) NOT AT ALL	☐

3. How often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you at night or earlier than usual in the morning?

IN THE PAST 4 WEEKS:	(1) 4 OR MORE NIGHTS/WEEK	(2) 2 – 3 NIGHTS/WEEK	(3) ONCE A WEEK	(4) ONCE OR TWICE	(5) NOT AT ALL	☐
IN THE PAST 6 MONTHS:	(1) 4 OR MORE NIGHTS/WEEK	(2) 2 – 3 NIGHTS/WEEK	(3) ONCE A WEEK	(4) ONCE OR TWICE	(5) NOT AT ALL	☐

4. How often have you used your rescue inhaler of nebulizer medication such as Albuterol?

IN THE PAST 4 WEEKS:	(1) 3 OR MORE TIMES/DAY	(2) 1 -2 TIMES/DAY	(3) 2 -3 TIMES/WEEK	(4) ONCE A WEEK OR LESS	(5) NOT AT ALL	☐
IN THE PAST 6 MONTHS:	(1) 3 OR MORE TIMES/DAY	(2) 1 -2 TIMES/DAY	(3) 2 -3 TIMES/WEEK	(4) ONCE A WEEK OR LESS	(5) NOT AT ALL	☐

5. How would you rate your asthma control?

IN THE PAST 4 WEEKS:	(1) NOT CONTROLLED AT ALL	(2) POORLY CONTROLLED	(3) SOMEWHAT CONTROLLED	(4) WELL CONTROLLED	(5) COMPLETELY CONTROLLED	☐
IN THE PAST 6 MONTHS:	(1) NOT CONTROLLED AT ALL	(2) POORLY CONTROLLED	(3) SOMEWHAT CONTROLLED	(4) WELL CONTROLLED	(5) COMPLETELY CONTROLLED	☐

TOTAL

If your child has seen an allergist, please list name of doctor _____Last visit _____Next visit _____

List current medications: _____

Do you check peak flows? ___Yes ___No; if yes, what is your personal best peak flow? _____

What was your peak flow over the past few weeks? _____

How many courses of oral steroids have you taken this past year? (Orapred, Prednisone, Prednisolone) _____

Is there any exposure to cigarette smoke? ____Yes ____No

Do you have any environmental allergies? ____Yes ____No. If yes, to what _____

OVER

Please list dates of any ER or Urgent Care visits due to asthma in the last year? _____

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