



Asthma Control Test (ACT)

(to be completed if you have a history of Asthma)

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

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