MedStar Georgetown University Hospital

Asthma Control Test® (ACT)

Name: ______________________________ Date: ______________

Date of Birth: __________________ Doctor: ______________________

1. In the past four weeks, how much of the time did your asthma keep you from getting much done at work, school or at home?										**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. In the past four weeks, how often have you had shortness of breath?										
More than once a day	1	Once a day	2	Two to six times a week	3	Once or twice a week	4	Not at all	5	
3. During the past four weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier in the morning?										
Four or more nights a week	1	Two or three nights a week	2	Once a week	3	Once or twice	4	Not at all	5	
4. During the past four weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)										
Three or more times a day	1	One or two times a day	2	Two or three times a week	3	Once a week or less	4	Not at all	5	
5. How would you rate your asthma control over the past four weeks?										
Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5	
								Patient Total Score		

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