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ASTHMA CONTROL TEST

Patient Name _____

Date of Birth _____

Date _____

**PLEASE CAN YOU COMPLETE THIS FORM AND RETURN IT TO RECEPTION AT:
Merrow Park Surgery**

The following test can help people with asthma assess their asthma control. Please tick the appropriate score for each question. There are five questions in total. Calculate your total Asthma Control Test score by adding up the numbers for each of your responses. Please answer the questions as honestly as possible. **If you score less than 20** your asthma may not be as well controlled as it could be. Please make an appointment with reception to see the Practice Nurse.

1. During the **past 4 weeks**, how often did your asthma prevent you from getting as much done at work, school or home?

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

Score _____

2. During the **past 4 weeks**, how often have you had wheeze or shortness of breath?

1 More than once a day **2** Once a day **3** 3-6 times a week **4** 1-2 times a week **5** Not at all

Score _____

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?

1 4 or more times a week **2** 2-3 nights a week **3** Once a week **4** Once or twice **5** Not at all

Score _____

4. During the **past 4 weeks**, how often have you used your rescue inhaler (such as Salbutamol)?

1 3 or more times a day **2** 1-2 times a day **3** 3-4 times a week **4** Once a week or less **5** Not at all

Score _____

5. How would you rate your asthma control during the **past 4 weeks**?

1 Not controlled **2** Poorly controlled **3** Somewhat controlled **4** Well controlled **5** Completely controlled

Score _____

Total	
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