PEDIATRIC ASSOCIATES OF KINGSTON
Taking Exceptional Care of the Next Generation since 1967

NEPA BREASTFEEDING CENTER

Date: _____

Asthma Control Test

Patient Name:_____ DOB:_____

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 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

2. During the past **4 weeks**, how often have you had shortness of breath?
    1. More than once a day
    2. Once a day
    3. 3-6 times a week
    4. Once or Twice a week
    5. Not at all

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 nights a week
    2. 2 or 3 nights a week
    3. Once a week
    4. Once or twice
    5. Not at all

4. During the past **4 weeks**, how often have you used our rescue inhaler or nebulizer medication (such as Albuterol, Ventolin, Proventil, or Maxair)?
    1. 3 or more times a day
    2. 1-2 times a day
    3. 2 or 3 times a week
    4. Once a week or less
    5. Not at all

5. How would you rate your **asthma** control during the **past 4 weeks**?
    1. Not controlled at all
    2. Poorly controlled
    3. Somewhat controlled
    4. Well controlled
    5. Completely controlled