Enter Name _____ Today's Date: _____

Patient DOB _____ Patient's Name: _____

_____

FOR PATIENTS:

Take the Asthma Control Test™ (ACT) for people 12 yrs and older.

Know your score. Share your results with your doctor.

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for your total.

Step 3 Take the test to the doctor to talk about your score.

									SCORE
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	
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	
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	
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	
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	
											TOTAL

If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.

FOR PHYSICIANS:

The ACT is:

- A simple, 5-question tool that is self-administered by the patient
- Clinically validated by specialist assessment and spirometry[1]
- Recognized by the National Institutes of Health

Reference: 1. Nathan RA et al. *J Allergy Clin Immunol.* 2004;113:59-65.

ASTHMA DATA COLLECTION FORM

PARENTS – PLEASE COMPLETE

Patient Name:	
Date of Birth:	**Date of Visit:**
Insurance: **Office Location:**	
Provider Seen Today:	

1. Has your child visited the Emergency Room or Urgent Care due to **asthma** in the last 6 months?

☐ Yes ☐ No

2. Has your child been admitted to the hospital due to **asthma** in the last 6 months?

☐ Yes ☐ No

3. How many days of work have you and/or your partner missed due to your child's **asthma** in the last 6 months? ☐

4. How many days of school has your child missed due to **asthma** in the last 6 months?

☐

5. Does your child have frequent nose and/or eye symptoms (running nose, nose rubbing, sneezing) in the spring or fall? ☐ Yes ☐ No

6. Is your child prescribed a **daily controller asthma medication?** ☐ **Yes** ☐ **No** (if No, go to 7.)

Examples of daily controller asthma medications include: Advair, Asmanex, Budesonide, Dulera, Flovent, QVAR, Pulmicort, Singulair, Symbicort

a. How often do you **forget to give or miss** your Childs's **daily** controller asthma medication?

☐ My child is not supposed to take a daily asthma medicine

☐ None of the time

☐ Some of the time 1-2 days/week

☐ Most of the time 3-4 days/week

☐ All of the time 5-7 days/week

7. Has your child received a flu vaccine (flu shot) in the last year?

☐ Yes ☐ No ☐ I don't know

7a. If yes, what (month and year) did your child receive his/her flu vaccine: _____/_____

8. Ethnicity_____ 9. Race_____

Please Take the Asthma Control Test TM

Total Score ☐

Version 4.2018

FOR OFFICE USE ONLY

Patient Name:	**Patient Status:** ☐ Active ☐ Exempt
Date of Birth: **Date of Visit:**	**Reason for Exempt:** ☐ Lung disease of prematurity ☐ Cystic Fibrosis ☐ Significant cardiac abnormalities ☐ Significant neuromuscular disorder ☐ Other: _____
Insurance: **Location:**	
Provider:	

Providers – Please complete the following sections:

1. How would you classify the patient's asthma severity? (check one) ☐ Persistent ☐ Intermittent ☐ EIB

2. Is the patient on a controller or was a controller started at this visit? ☐ Yes ☐ No ☐ Contraindicated ☐ Refused

If **'Yes'** please complete **Medications** section below.

3. Has the patient been on rescue oral steroids in the last 6 months? ☐ Yes ☐ No

4. How many times has the patient been to the ER or Urgent Care due to asthma in the last 6 months?

5. How many times has the patient been hospitalized due to asthma in the last 6 months?

6. Have you obtained a pulmonary function test on this patient in the 12 months? ☐ Yes ☐ No ☐ Referred

7. Does the patient see an asthma specialist as part of their regular care? ☐ Yes ☐ No ☐ Referred

If "Yes", who? ☐ CAAC ☐ NJH ☐ CHCO ☐ Other ☐ RMHC ☐ Denver/BV A&A ☐ Other

8. What was the date of the patient's last influenza vaccination? (mo./yr.) _____/_____

8a. If the patient did not have an influenza vaccination is the patient contraindicated or did they actively refuse?
☐ Contraindicated ☐ Refused

Medications

Please complete/update the following information regarding controller medications

Notes:	**Date Started:**
Inhaled Corticosteroid (Ex. QVAR, Pulmicort, Flovent, Asmanex)	☐ Add ☐ Continue ☐ Discontinue
Inhaled Corticosteroid with Long Acting Beta Agonist (Ex. Symbicort, Advair)	☐ Add ☐ Continue ☐ Discontinue
Leukotriene Antagonists (Ex. Singulair, Monteleukast)	☐ Add ☐ Continue ☐ Discontinue
Other Asthma Controller (not Albuterol)	☐ Add ☐ Continue ☐ Discontinue

Counseling

Does this patient have an asthma action plan (created by a primary care provider or a specialist) that has been discussed or created at this visit? ☐ Yes ☐ No

Has the patient/family been counseled on MDI technique, spacer, and/or nebulizer use at this visit? ☐ Yes ☐ No

Is the patient exposed to smoke? ☐ **Yes** ☐ **No**

If 'Yes', did you provide counseling regarding smoke exposure at this visit? ☐ **Yes** ☐ **No**