Adult Asthma Management Questionnaire

Mayo Clinic Number	Patient Name (first, middle, last)	Today date (MM DD, YYYY)

The Asthma Management Questionnaire is designed to help you and your health care provider manage your asthma. Today you may not be seeing your provider for asthma; however, we ask that you take the time to complete this form.

Instructions: Please complete all sections of the form, by filling in the appropriate circle(s) like ● .

1. In the last 12 months, approximately how many:

Visits have you made to an emergency room for your asthma?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ =>10

Days have you been hospitalized for asthma care?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ =>10

Office visits have you had for asthma care?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ =>10

Days have you missed from work/school due to your asthma symptoms?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ =>10

Courses of oral steroid, (e.g. prednisone) (pills or liquid) have you had?
○ 0 ○ 1 ○ 2 ○ 3 ○ =>4

2. How many canisters of your rescue inhaler (albuterol) have you used in the last 3 months ?
○ 0 ○ 1 ○ 2 ○ 3 ○ =>4

3. How often are you able to take your medication as prescribed?
○ 0 None of the time ○ 25% ○ 50% ○ 75% ○ 100% All of the time

For the following questions fill in all that apply.

4. Do any of the following triggers make your asthma worse?

○ Animals/pets	○ Pollen	○ Respiratory infections	○ Asprin or Beta Blockers
○ Cockroaches	○ Trees	○ Exercise	○ Stress/anxiety
○ Dust mites	○ Molds	○ Chemicals and fumes	○ Other triggers
○ Grass	○ Other allergies	○ Weather/Temperature	

5. Where are you exposed to your triggers? ○ Work/Occupation ○ Home ○ School

6. Do you have the following conditions that may make your asthma worse?
○ GI/Acid Reflux ○ Sneezing/Congestion (Rhinitis) ○ Sinusitis ○ Sleep Apnea

7. What is your current tobacco smoke exposure?
○ None ○ Secondhand smoke ○ Former smoker ○ Current smoker

Do not mark below this line -- Office use only

○ Pt. declined.

Asthma Control Test™

This survey was designed to help you describe your asthma and how your asthma affects how you feel and what you are able to do. To complete it, please fill in the bubble ● that best describes your answer.

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	Most of the time	Some of the time	A little of the time	None of the time
○1	○2	○3	○4	○5

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

More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all
○1	○2	○3	○4	○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	2 to 3 nights a week	Once a week	Once or twice	Not at all
○1	○2	○3	○4	○5

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as Albuterol , Ventolin®, Proventil®, Maxair®, or Primatene Mist®)?

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

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

Not Controlled at all	Poorly Controlled	Somewhat Controlled	Well Controlled	Completely Controlled
○1	○2	○3	○4	○5

To score the ACT

Each response to the 5 ACT questions has a point value from a 1 to 5 as shown on the form. To score the ACT add up the point values for each response to all five questions

If your total point value is 19 or below, your asthma may not be well-controlled. Be sure to talk to your healthcare professional about your asthma score

Take this survey to your healthcare professional and talk about your asthma treatment plan.

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