SALISBURY MEDICAL PRACTICE

Help us to manage your Asthma - Take the Asthma Control Test

Name: *Please print*		Date of birth:	

How often in the last 4 weeks… *(Please tick one option from each box)*

	Not limiting activities	**1-2 times per month**	**1-2 times per week**	**Most days and nights**
Has your asthma limited your activities?				
Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?				
Have you had difficulty sleeping because of your asthma symptoms (including cough)?				

Does your asthma prevent you from getting as much done at work/school/home?	All of the time	
	Most of the time	
	Some of the time	
	A little of the time	
	None of the time	
Have you had shortness of breath?	More than once a day	
	Once a day	
	3-6 times a week	
	1-2 times a week	
	None at all	
Do your asthma symptoms wake you up at night or early in the morning?	4 or more times a week	
	2-3 nights a week	
	Once a week	
	Once or twice	
	Not at all	
Have you used your reliever inhaler (usually blue)?	3 or more times a day	
	1-2 times a day	
	2-3 times a day	
	Once a week or less	
	Not at all	
How would you rate your asthma control?	Not controlled	
	Poorly controlled	
	Somewhat controlled	
	Well controlled	
	Completely controlled	

Are you a smoker?	Yes		Ex-smoker		
	Use a vape		Never smoked		
Would you like help to stop smoking?		Yes		No	

Please tick this box if you are happy for us to contact you regarding your responses				
Preferred contact number				
Do you consent contact by an SMS message?	Yes		No	

For admin purposes - please initial here when completed to patient notes: