A-Star
The UK-Irish Atopic Eczema Systemic Therapy Register
A PROJECT OF THE BRITISH ASSOCIATION OF DERMATOLOGISTS

Patient initials: _____-_____
Patient study ID: _____ - _____
Name of visit: _____
Date of completion: _____ / _____ / _____

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 mark an ☒ in the one box that best describes your answer.

1. During the last 4 weeks, how much of the time has your asthma kept you from getting as much done at work, school or 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 last 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 last 4 weeks, how often have your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) woken 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 last 4 weeks, how often have you used your rescue inhaler or nebuliser medication (such as Salbutamol)?

3 or more times per day	Once or twice 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 last 4 weeks?

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

TOTAL SCORE: ☐