Westside Allergy Care

Patient Name:__________________________ Date of Visit: ______________________________

If you have asthma, answer the questions and record your answers in the boxes.

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 the time:	**1**	**Most of the time:**	**2**	☐
Some of the time:	**3**	**A little:**	**4**	
None of the time:	**5**			

In the past 4 weeks, how often have you had **shortness of breath**?

More than once a day:	**1**	**Once a day:**	**2**	☐
3-6 times a week:	**3**	**Once or twice a week:**	**4**	
Not at all:	**5**			

During the past 4 weeks, how often did your **asthma symptoms** awaken you at night or earlier than usual in the morning?

4 or more nights a week:	**1**	**Twice or 3 nights a week:**	**2**	☐
Once a week:	**3**	**Once or twice a month:**	**4**	
Not at all:	**5**			

During the past 4 weeks, how often have you used your **rescue inhaler or nebulizer medication**?

More than 3 times a day:	**1**	**1-2 times a day:**	**2**	☐
2-3 times a week:	**3**	**Once a week or less:**	**4**	
None:	**5**			

How would you describe your **asthma control** during the past 4 weeks?

Control is: Not Controlled:	**1**	**Poorly controlled:**	**2**	☐
Somewhat Controlled:	**3**	**Pretty well controlled:**	**4**	
Completely controlled:	**5**			

Add your answers and write your total score in the box. ☐