Asthma Control Test

SAN FRANCISCO HEALTH PLAN™
Here for you

A quick test that provides a numerical score to assess asthma control.
For adults and children 12 years or older.

STEP 1: Answer each question and write the answer number in the SCORE box to the right of each question.

STEP 2: Add your answers and write your total score in the TOTAL box shown below.

STEP 3: Take this test form to your next appointment and discuss your results with your provider.

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?

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

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

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

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?

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

4. During the past **4 weeks,** how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

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

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

1	Not controlled at all	**2**	Poorly controlled	**3**	Somewhat controlled	**4**	Well controlled	**5**	Completely controlled

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TOTAL

If your score is 19 or less, your asthma may not be under control. Be sure to talk with your provider about your results.

Mail your completed and signed form to us in the enclosed, self-addressed envelope or fax it to us at 1(415) 615-4547.

Get a FREE **$25** Gift Card!

Once we receive it, we will mail you a **$25 gift card.** It may take 4-6 weeks after we get your form to get your gift card.

You can receive only one gift card per calendar year for getting all your tests done.

All forms must be completed and signed by your provider.

Select one:

☐ $25 TARGET ☐ $25 Walgreens

MEMBER INFORMATION

Member Name:

Street Address:

City, State, Zip:

SFHP ID#:

PRIMARY CARE PROVIDER INFORMATION

Provider Name:

Clinic Name:

Street Address:

City, State, Zip:

Provider Phone:

X

PROVIDER SIGNATURE DATE