

**YOU MAY PRINT THIS FORM AND FILL OUT PRIOR TO YOUR VISIT. THIS FORM MUST BE COMPLETED BY THE PATIENT BEFORE SEEING THE DOCTOR TO COMPLY WITH INSURANCE REQUIREMENTS / DOCUMENTATION**

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PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DATE \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

And/or circle items if applicable: Routine visit    Need refills    Sneezing    Runny nose    Itchy eyes    Cough

Wheeze    Asthma    Respiratory infection    Sinusitis    Headache    Fever    Earache    Discolored discharge

NEW PROBLEMS SINCE LAST VISIT: \_\_\_\_\_

PREVIOUS PROBLEMS: STABLE \_\_\_\_\_ OR WORSENING (describe) \_\_\_\_\_

LIST ALL MEDICATIONS PRESCRIBED TO YOU BY ALL PHYSICIANS ALONG WITH THE DOSE YOU TAKE. NOTE: WE CAN ONLY REFILL MEDICATIONS PRESCRIBED TO YOU BY US.

	<u>MEDICATION</u>	<u>DOSE</u>	<u>TIMES TAKEN IN A DAY</u>	<input checked="" type="checkbox"/> <u>REFILLS</u> (only if needed)
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____
6)	_____	_____	_____	_____
7)	_____	_____	_____	_____
8)	_____	_____	_____	_____
9)	_____	_____	_____	_____
10)	_____	_____	_____	_____

IF YOU MAIL YOUR PRESCRIPTIONS, DOES YOUR INSURANCE REQUIRE A 90 DAY SUPPLY ? \_\_\_\_\_  
OR, DO YOU FILL YOUR PRESCRIPTIONS AT A LOCAL PHARMACY ? \_\_\_\_\_

ANY ALLERGIES TO MEDICATIONS \_\_\_\_\_

**have asthma? complete reverse side of form - ACT SCORE**

**FOR MEDICAL STAFF:**

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ PF \_\_\_\_\_  
TEMP \_\_\_\_\_

## ASTHMA CONTROL TEST (ACT)

**This form must be completed by the patient to comply with insurance requirements / documentation.**

Please circle **ONE** answer for each of the **5** questions below and review your results with your physician.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work or at home?

<b>1</b> All of the time	<b>2</b> Most of the time	<b>3</b> Some of the time	<b>4</b> A little of the time	<b>5</b> None of the time
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2. During the past 4 weeks, how often have you had shortness of breath?

<b>1</b> More than once a day	<b>2</b> Once a day	<b>3</b> 3 to 6 times a week	<b>4</b> Once or twice a week	<b>5</b> Not at all
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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?

<b>1</b> 4 or more nights a week	<b>2</b> 2 to 3 nights a week	<b>3</b> Once a week	<b>4</b> Once or twice	<b>5</b> Not at all
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4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

<b>1</b> 3 or more times per day	<b>2</b> 1 to 2 times per day	<b>3</b> 2 or 3 times per week	<b>4</b> Once a week or less	<b>5</b> Not at all
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5. How would you rate your asthma control during the past 4 weeks?

<b>1</b> Not controlled at all	<b>2</b> Poorly controlled	<b>3</b> Somewhat controlled	<b>4</b> Well controlled	<b>5</b> Completely controlled
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**TOTAL SCORE \_\_\_\_\_ (please enter score on the other side of this form)**

If your total score is 19 or less, your asthma may not be as well controlled as it could be.