Adult Asthma Therapy Assessment Questionnaire

Patient Name:_____

ID Number:_____

Physician Name:_____ Date:_____

INSTRUCTIONS: Check 1 answer to each question and enter point value (0 or 1) on line

	Control Issues	Other Issues

1. In the *past 4 weeks*, did you:

a) Miss any work, school, or normal daily activity because of your asthma? ☐ Yes (1) ☐ No (0) ☐ Unsure (1) ____

b) Wake up at night because of asthma? ☐ Yes (1) ☐ No (0) ☐ Unsure (1) ____

2. Do you use an inhaler for *quick relief* from asthma symptoms? ☐ Yes ☐ No ☐ Unsure

(If Yes) In the **past 4 weeks**, what was the **highest number of puffs in 1 day** you took of the inhaler?

0 puffs	☐ (0)	9 to 12 puffs	☐ (1)*
1 to 4 puffs	☐ (0)	More than 12 puffs	☐ (1)
5 to 8 puffs	☐ (1)*	**Enter score**	____

*This reflects a lower threshold to identify potential control problems than was used in the ATAQ validation studies. This modification was designed to encourage patients and providers to discuss how asthma medications are being used.

3. Has your doctor or medical provider ever prescribed an asthma inhaler or pill that is NOT used for quick relief but is used to *control* your asthma? ☐ Yes ☐ No ☐ Unsure

(If Yes) Which statement best describes how you take this medicine now?

I take it every day.	☐ (0)	I take it only when I have symptoms.	☐ (1)
I take it some days, but other days I don't.	☐ (1)	I never take it.	☐ (1)
I used to take it, but now I don't.	☐ (1)	**Enter score**	____

4. Are you dissatisfied with any part of your *current* asthma treatment? ☐ Yes (1) ☐ No (0) ☐ Unsure (1) ____

5. Do you believe that:

a) Your asthma was well controlled in the **past 4 weeks**? ☐ Yes (0) ☐ No (1) ☐ Unsure (1) ____

b) You are able to take your asthma medicine(s) as directed? ☐ Yes (0) ☐ No (1) ☐ Unsure (1) ____

c) Your medicine(s) is useful in controlling your asthma? ☐ Yes (0) ☐ No (1) ☐ Unsure (1) ____

6. During this office visit, would you like your doctor to discuss:

a) Different types of drugs available to control asthma? ☐ (1)

b) Asthma treatment options? ☐ (1)

c) Your preferences for taking asthma medicine(s)? ☐ (1)

d) Other issues? ☐ (1)

Enter score ____

Add numbers in the light blue area and enter total SCORE here. **TOTAL** ____

Add numbers in the dark blue area and enter total SCORE here. **TOTAL** ____

If either SCORE is 1 or greater, discuss questionnaire with your doctor.

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