



Asthma Therapy Assessment Questionnaire*

Take a step toward control ADULT (18 YEARS OR OLDER)

Patient's name: _____

ID number: _____

Physician's name: _____ Date: _____

Instructions: Check 1 answer for each question and enter point value (0 or 1) on line.

Control Issues **Enter score**
Other Issues **Enter score**

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) **Enter score** → _____

b. Wake up at night because of asthma?

Yes (1) No (0) Unsure (1) **Enter score** → _____

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 (0) 5 to 8 puffs (1)* More than 12 puffs (1)

1 to 4 puffs (0) 9 to 12 puffs (1)*

Enter score → _____

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

3. Has your doctor or health care 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 do not. (1) I never take it. (1)

I used to take it, but now I do not. (1)

Enter score → _____

4. Are you dissatisfied with any part of your *current* asthma treatment?

Yes (1) No (0) Unsure (1) **Enter score** → _____

5. Do you believe that:

a. Your asthma was well controlled in the **past 4 weeks**? Yes (0) No (1) Unsure (1) **Enter score** → _____

b. You are able to take your asthma medicine(s) as directed? Yes (0) No (1) Unsure (1) **Enter score** → _____

c. Your medicine(s) is useful in controlling your asthma? Yes (0) No (1) Unsure (1) **Enter score** → _____

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

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

Asthma treatment options? (1)

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

Other issues? (1)

Enter score → _____

Add the numbers in the **light blue** area and enter the total **score** here.

TOTAL → _____

Add the numbers in the **dark blue** area and enter the total **score** here.

TOTAL → _____

If either **score is 1 or greater**, discuss the questionnaire with your doctor.