

# The 30 Second Asthma Test<sup>®</sup>

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| <b>1. Do you use your fast-acting reliever inhaler 4 or more times a week?</b><br>(Including doses used for exercise) | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>2. Do you cough, wheeze, or have a tight chest because of your asthma?</b><br>(4 or more days a week)              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3. Do coughing, wheezing, or chest tightness wake you at night?</b><br>(1 or more times a week)                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>4. Do you stop exercising because of your asthma?</b><br>(In the past 3 months)                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>5. Do you ever miss work, school, or social activities because of your asthma?</b><br>(In the past 3 months)       | <input type="checkbox"/> | <input type="checkbox"/> |

***Even one "yes" means see your doctor.  
Your asthma is not under control.***

An initiative of  GlaxoSmithKline