

Patient Name: _____

Today's Date: _____

Patient DOB: _____







Childhood Asthma Control Test™ For Children 4 - 11 years of age

This short quiz will provide a score that will help us determine if your child's treatment plan is working or if it might be time for a change.

Have your child complete these questions. If your child needs help reading or understanding the question, you may help, but let your child select the response





1. How is your asthma today?

 0 Very bad	 1 Bad	 2 Good	 3 Very good
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2. How much of a problem is your asthma when you run, exercise or play sports?

 0 It's a big problem, I can't do what I want to do.	 1 It's a problem and I don't like it.	 2 It's a little problem but it's okay.	 3 It's not a problem.
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3. Do you cough because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.
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4. Do you wake up during the night because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.
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SCORE

Parents, please complete the following questions without letting your child's response influence your answers.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
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6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
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7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
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TOTAL

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Asthma Control

How would you rate your child's asthma control during the past month?

Very poorly controlled Poorly controlled Well controlled

How comfortable are you in your ability to manage your child's asthma? Rate on a scale of 1-10.

Not Comfortable = 1 Very Comfortable = 10 Score: _____

Visits to Other Providers

How many times had your child been to the ER/Urgent care for asthma related issues in the past year? _____

How many times has your child been admitted to the hospital for asthma related issues in the last year? _____

If admitted, was he/she in ICU? _____

Has your child ever been referred to an asthma specialist? Yes No

• If yes, what is the name of that provider and when was his/her last visit? _____

Medications

How many times has your child been prescribed oral steroids this past year? _____

Please circle which (if any) **medications are used every day**

Symbicort inhaler Advair Diskus Pulmicort Flexhaler Singulair tablet
 Qvar inhaler Flovent Diskus Pulmicort respules for nebulizer

Please circle which (if any) **rescue/emergency medications are used as needed** for asthma symptoms?

Albuterol inhaler (such as: ProAir, Xopenex inhaler Allergy medication (such as Zyrtec, Claritin, Allegra)
Proventil, Ventolin, RespiClick) Xopenex for nebulizer Nasal steroids (such as Nasonex, Flonase, etc.)
 Albuterol for nebulizer

If your child has rescue/emergency inhaler to use when asthma symptoms worsen, does he/she have a spacer? _____

• If yes, does your child use the spacer? Yes No Not sure

Triggers and Allergies

When are your child's asthma symptoms worse? Click all applicable. Winter Spring Summer Fall

Is your child exposed to any second hand smoke? Yes No

Please check all triggers that make your child's asthma worse:

<input type="checkbox"/> Respiratory infections	<input type="checkbox"/> Exercise/increased activity	<input type="checkbox"/> Strong cleaners, air fresheners, aerosols, etc.	
<input type="checkbox"/> Heat/humidity	<input type="checkbox"/> Tobacco smoke	<input type="checkbox"/> Carpeting	<input type="checkbox"/> Perfumes
<input type="checkbox"/> Changes in weather	<input type="checkbox"/> Wood smoke	<input type="checkbox"/> Cockroaches	<input type="checkbox"/> None
<input type="checkbox"/> Cold Air	<input type="checkbox"/> Air pollution	<input type="checkbox"/> Pollen	<input type="checkbox"/> Don't know
<input type="checkbox"/> AC/Heating	<input type="checkbox"/> Dust	<input type="checkbox"/> Mold	<input type="checkbox"/> Other: _____

Has your child had allergy testing? Yes No

• If yes, what were his/her reported allergies? _____

Prevention

Is your child going to receive or already received the flu vaccine this year? Yes No

Does your child have an asthma action plan at home and school? Yes No