

Patient Name: _____

Today's Date: _____

Patient DOB: _____



Asthma Control Test™ For 12 years and older

This short quiz will provide a score that will help us determine if your asthma treatment plan is working or if it might be time for a change. **Have your child complete these questions.**

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

All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5
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SCORE

2. During the past **4 weeks**, how often have you had shortness of breath?

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

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

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

Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5
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TOTAL

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If your score is 19 or less, your asthma may not be controlled as well as it could be. We will discuss this today.

Patient Name: _____

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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"/> Changes in weather | <input type="checkbox"/> Wood smoke | <input type="checkbox"/> Cockroaches |
| <input type="checkbox"/> Cold Air | <input type="checkbox"/> Air pollution | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> AC/Heating | <input type="checkbox"/> Dust | <input type="checkbox"/> Mold |
| | | <input type="checkbox"/> Perfumes |
| | | <input type="checkbox"/> None |
| | | <input type="checkbox"/> Don't know |
| | | <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