Patient Name: _____ Today's Date: _____

Patient DOB: _____

pediatric associates of austin, p.a.

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.**

										SCORE
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	
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	
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	
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	
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	
											TOTAL

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: _____ Today's Date: _____

Patient DOB: _____

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

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:

☐ Respiratory infections
☐ Heat/humidity
☐ Changes in weather
☐ Cold Air
☐ AC/Heating
☐ Exercise/increased activity
☐ Tobacco smoke
☐ Wood smoke
☐ Air pollution
☐ Dust
☐ Strong cleaners, air fresheners, aerosols, etc.
☐ Carpeting
☐ Cockroaches
☐ Pollen
☐ Mold
☐ Perfumes
☐ None
☐ Don't know
☐ 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