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	1	2	3	SCORE
Very bad	Bad	Good	Very good	☐

2. How much of a problem is your asthma when you run, exercise or play sports?

0	1	2	3	
It's a big problem, I can't do what I want to do.	It's a problem and I don't like it.	It's a little problem but it's okay.	It's not a problem.	☐

3. Do you cough because of your asthma?

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

4. Do you wake up during the night because of your asthma?

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

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

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

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

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

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

TOTAL ☐

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)

☐ Albuterol for nebulizer

☐ Xopenex inhaler

☐ Xopenex 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 ☐ Exercise/increased activity ☐ Strong cleaners, air fresheners, aerosols, etc.

☐ Heat/humidity ☐ Tobacco smoke ☐ Carpeting ☐ Perfumes

☐ Changes in weather ☐ Wood smoke ☐ Cockroaches ☐ None

☐ Cold Air ☐ Air pollution ☐ Pollen ☐ Don't know

☐ AC/Heating ☐ Dust ☐ Mold ☐ 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