AUSTIN REGIONAL CLINIC

Pediatric Asthma Control Assessment

Patient Name: _____ Date: _____

Please answer all the questions below in the space provided on the right.

In the past 6 months:

1	Has your asthma been any worse?	NO	YES
2	Have there been any changes in your home, work, or school environment? (such as a new pet, someone smoking)	NO	YES
3	Have you had any times when you symptoms were a lot worse than usual?	NO	YES
4	Has your child's asthma caused him/ her to miss school or reduce or change your activities?	NO	YES
5	Have you missed any regular doses of your medicines for any reason?	NO	YES
6	Have your medications caused you any problems? (shakiness, nervousness, bad taste, sore throat, cough, upset stomach)	NO	YES
7	Have you had any after hours visits, emergency room visits, or hospital stays for asthma?	NO	YES
8	Has the cost of your asthma treatment kept you from getting the medicine or care you need for your asthma?	NO	YES

In the past 4 weeks:

9 Have you had a cough, wheezing, shortness of breath, or chest tightness during:

- the day _____ # of Days
- the night _____ # of Days
- exercise or play _____ # of Days

10 How many days have you used your rescue medication (inhaler or nebulizer)? _____ # of Days
(includes Albuterol, Ventolin, Proventil, Xopenex)

11	(If you use a peak flow meter) Did your peak flow go below 80 percent of your personal best?	NO	YES
12	Have you been satisfied with the way your asthma has been?	NO	YES

In the past week:

13 How many days have you used your inhaled quick-relief medicine (inhaler or nebulizer)? _____ # of Days

14 How often did your child need a fast acting or quick relief medication (rescue inhaler) at times other than before exercise? (includes Albuterol, Ventolin, Proventil, Xopenex) _____ # of Days

15	Are there things about your child's asthma you want to discuss with your physician today?	NO	YES

At this visit:

16 How comfortable do you feel in managing your child's asthma?
Not Comfortable= ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 = Very Comfortable

17 What would make you feel more comfortable/ confident? _____

_____

For New Patients:

18	Does your child use a spacer with his/ her inhaler?	NO	YES

19 When are asthma symptoms worse?
☐ Winter ☐ Spring ☐ Summer ☐ Fall ☐ All ☐ None

20 Please mark all things that make your child's asthma worse
☐ Respiratory Infections ☐ Exercise ☐ Irritants (Tobacco, Smoke, Air Pollution, Perfumes, Incense, Other Irritants)
☐ Cold Air ☐ Heat/ Humidity ☐ Don't know
☐ Changes in Weather ☐ None
☐ Allergens (Animals, Dust, Pollen, Mold, Food) ☐ Other _____

21 How often does asthma limit your child's activities?
☐ Not at all ☐ a little of the time ☐ some of the time ☐ most of the time ☐ all of the time

22 How would you rate your child's asthma control during the past month?
☐ well controlled ☐ somewhat controlled ☐ poorly controlled

23 Receiving the flu vaccine yearly is a highly important step in controlling your child's asthma. Would you like to have your child receive the vaccine this year? ☐ YES ☐ NO- Reason _____