Patient Name _____ Today's Date: _____

Patient DOB: _____ Patient's Name: _____

Childhood Asthma Control Test for children 4 to 11 years.

This test will provide a score that may help the doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to **the first four questions (1 to 4)**. If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining **three questions (5 to 7)** on your own and without letting your child's response influence your answers. There are no right or wrong answers.

Step 2 Write the number of each answer in the score box provided.

Step 3 Add up each score box for the total.

Step 4 Take the test to the doctor to talk about your child's total score.

19 or less If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. Bring this test to the doctor to talk about the results.

Have your child complete these questions.

1. How is your asthma today?

 0 Very bad	 1 Bad	 2 Good	 3 Very good

SCORE ☐

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.

☐

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.

☐

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.

☐

Please complete the following questions on your own.

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

☐

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

☐

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

☐

TOTAL ☐

ASTHMA DATA COLLECTION FORM

PARENTS – PLEASE COMPLETE

Patient Name:	
Date of Birth:	**Date of Visit:**
Insurance: **Office Location:**	
Provider Seen Today:	

1. Has your child visited the Emergency Room or Urgent Care due to **asthma** in the last 6 months?

☐ Yes ☐ No

2. Has your child been admitted to the hospital due to **asthma** in the last 6 months?

☐ Yes ☐ No

3. How many days of work have you and/or your partner missed due to your child's **asthma** in the last 6 months? ☐

4. How many days of school has your child missed due to **asthma** in the last 6 months?

☐

5. Does your child have frequent nose and/or eye symptoms (running nose, nose rubbing, sneezing) in the spring or fall? ☐ Yes ☐ No

6. Is your child prescribed a **daily controller asthma medication?** ☐ **Yes** ☐ **No** (if No, go to 7.)

Examples of daily controller asthma medications include: Advair, Asmanex, Budesonide, Dulera, Flovent, QVAR, Pulmicort, Singulair, Symbicort

a. How often do you **forget to give or miss** your Childs's **daily** controller asthma medication?

☐ My child is not supposed to take a daily asthma medicine

☐ None of the time

☐ Some of the time 1-2 days/week

☐ Most of the time 3-4 days/week

☐ All of the time 5-7 days/week

7. Has your child received a flu vaccine (flu shot) in the last year?

☐ Yes ☐ No ☐ I don't know

7a. If yes, what (month and year) did your child receive his/her flu vaccine: _____/_____

8. Ethnicity_____ 9. Race_____

Please Take the Asthma Control Test TM

Total Score ☐

Version 4.2018

FOR OFFICE USE ONLY

Patient Name:	**Patient Status:** ☐ Active ☐ Exempt
Date of Birth: **Date of Visit:**	**Reason for Exempt:** ☐ Lung disease of prematurity ☐ Cystic Fibrosis ☐ Significant cardiac abnormalities ☐ Significant neuromuscular disorder ☐ Other: _____
Insurance: **Location:**	
Provider:	

Providers – Please complete the following sections:

1. How would you classify the patient's asthma severity? (check one) ☐ Persistent ☐ Intermittent ☐ EIB

2. Is the patient on a controller or was a controller started at this visit? ☐ Yes ☐ No ☐ Contraindicated ☐ Refused

If **'Yes'** please complete **Medications** section below.

3. Has the patient been on rescue oral steroids in the last 6 months? ☐ Yes ☐ No

4. How many times has the patient been to the ER or Urgent Care due to asthma in the last 6 months?

5. How many times has the patient been hospitalized due to asthma in the last 6 months?

6. Have you obtained a pulmonary function test on this patient in the 12 months? ☐ Yes ☐ No ☐ Referred

7. Does the patient see an asthma specialist as part of their regular care? ☐ Yes ☐ No ☐ Referred

If "Yes", who? ☐ CAAC ☐ NJH ☐ CHCO ☐ Other ☐ RMHC ☐ Denver/BV A&A ☐ Other

8. What was the date of the patient's last influenza vaccination? (mo./yr.) _____/_____

8a. If the patient did not have an influenza vaccination is the patient contraindicated or did they actively refuse?
☐ Contraindicated ☐ Refused

Medications

Please complete/update the following information regarding controller medications

Notes:	**Date Started:**
Inhaled Corticosteroid (Ex. QVAR, Pulmicort, Flovent, Asmanex)	☐ Add ☐ Continue ☐ Discontinue
Inhaled Corticosteroid with Long Acting Beta Agonist (Ex. Symbicort, Advair)	☐ Add ☐ Continue ☐ Discontinue
Leukotriene Antagonists (Ex. Singulair, Monteleukast)	☐ Add ☐ Continue ☐ Discontinue
Other Asthma Controller (not Albuterol)	☐ Add ☐ Continue ☐ Discontinue

Counseling

Does this patient have an asthma action plan (created by a primary care provider or a specialist) that has been discussed or created at this visit? ☐ Yes ☐ No

Has the patient/family been counseled on MDI technique, spacer, and/or nebulizer use at this visit? ☐ Yes ☐ No

Is the patient exposed to smoke? ☐ **Yes** ☐ **No**

If 'Yes', did you provide counseling regarding smoke exposure at this visit? ☐ **Yes** ☐ **No**