



Orchard Pediatrics, P.C.

Newborn through Adolescent Care

ASTHMA CONTROL TEST AGES 0-4

Patient name: _____ DOB _____

OVER THE LAST 4 WEEKS:

How often does your child cough and/or wheeze?

- 0-2 days/wk 3-6 days/wk every day more than once a day

How often does your child wake up because of asthma?

- 0 night/month 1-2 nights/month 3-4 times/month more than once/wk

How much does asthma interfere with your child's activity?

- none a little some a lot

How often do you need to give your child Albuterol?

- 0-2 time/wk 3-6 times/wk daily more than once/day

How many courses of Orapred/Prednisone/Prelone has your child taken within the past year?

- 0-1 2-3 4+

Does anyone in the home smoke?

- yes no

Does your child have known environmental allergies?

- yes no If yes, to what? _____

Has your child been ill because of anything other than asthma during the past few weeks? _____

Please list dates of ER/Urgent Care/hospital visits because of asthma during the past year _____

Please list current medications _____

PARENT SIGNATURE

DATE