Orchard Pediatrics, PC

– Newborn through Adolescent Care –

TO BE COMPLETED BY PARENT

ASTHMA CONTROL TEST
AGES 0–4

TO BE COMPLETED BY PARENT

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

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